

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07453
345

Reg. Dist. No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Baltimore County
City or town University Park Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alfred Lunkof Bailey

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white widowed

6. (b) Name of husband or wife

Mary Gordon Bailey

7. Birth date of deceased (mo., day, yr.)

Dec 9, 1876/11 1860

6. (c) If alive, give age years

8. AGE: 87 years

Months

Days

If less than one day

(87) 11 9

7

5

hrs. min.

9. Birthplace

New Jersey (town, county, and state)

10. Usual occupation.

Retired - U.S. Government

11. Industry or business

Civil Lawyer

12. Name

New Jersey

13. Birthplace

Sarah A. Buxton

14. Maiden name

New Jersey

15. Birthplace

Mrs. W. B. Garrett

16. Informant

Burial

Cemetery or crematory

St. Lincoln

Location

Colmar Manor Md

18. Funeral director

F. Gaecher Sons

Address

Hyattsville Md

19. Date rec'd by registrar

July 16 1948 James E. Avery

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore Co
City or town University Park (If outside city or town limits, write RURAL and give nearest town)
Street No. 4325 Elgar Rd (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 14, 1948 at 12:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1948 to July 13 1948
and that I last saw him alive on July 13 1948

Immediate cause of death

Cerebral haemorrhage

Due to

do

Due to

Other conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

George W. Latimer M.D.
Hyattsville Md Date signed 7.14.48

RECEIVED
JUL 17 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136

07454
243

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

Prince Georges

County.....

Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos., 4 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 9 mos., 4 days

3. (a) FULL NAME

LAWRENCE BANKS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Divorced

6. (b) Name of husband or wife

Elizabeth Altterton

6. (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.)

September 24, 1916

8. AGE:

Years

Months

Days

If less than one day

31

31

9

13

hrs.

min.

9. Birthplace

Anderson, South Carolina

(Town, county, and state)

10. Usual occupation

Bellman, Ambassador Hotel

11. Industry or business

MOTHER

FATHER

12. Name

Dorce Banks

13. Birthplace

?

14. Maiden name

O. C. Henderson

15. Birthplace

?

16. Informant

Deceased

Address

Wesley D. C.

Date thereof July 7, 1948

Cemetery or crematory

Location

18. Funeral director

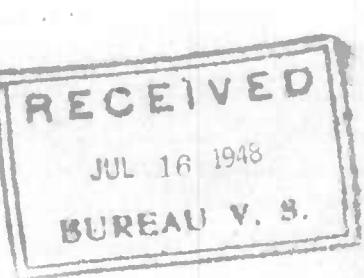
Address

19. Date rec'd by registrant

Date signed

Address

Date signed</div



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

466

07455

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George -
 City or town Columbia Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs
 Hospital, Institution, or street address where death occurred.

How long in hospital or institution?

3. (a) FULL NAME

Annie Barnacle

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white widowed

6. (b) Name of husband or wife James K. Barnacle

7. Birth date of deceased (mo., day, yr.) April 26, 1861

8. (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
87	3	-	hrs. min.

9. Birthplace Nash. D.C.

(Town, county, and state)

10. Usual occupation house duties

11. Industry or business

12. Name John Crowley

13. Birthplace Ireland

14. Maiden name Johanna Murphy

15. Birthplace Nash. D.C.

16. Informant Ralph F. Barnacle

Address Columbia Park Md.

17. Burial Date thereof July 30, 1948

(Burial, cremation, or removal. Which?) Cemetery or crematory Mt. Olivet

Location Washington D.C.

18. Funeral director Jackie Long

Address Hyattsville Md.

19. (Date rec'd by registrar) 7/27/48 1948 Ananda Doury

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town Columbia Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. none
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

more

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1948 at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1948 to July 26 1948

and that I last saw her alive on July 24 1948

Immediate cause of death carcinoma of stomach

DURATION 5 mns

Due to cause unknown

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE 3 M. Brady M.D. M. D. or other

Address Seal Pleasant Md. Date signed July 26, 1948

RECEIVED

JUL 29 1948

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

926

Reg. Dist. No. 5319

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Prince Georges
Oak Crest Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Powell M'Kinley Bassil

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

C.

Married

6. (b) Name of husband or wife

Ethel May Bassil

7. Birth date of deceased (mo., day, yr.)

May 18, 1900

6. (c) If alive, give age 46 years

8. AGE:

Years

Months

Days

If less than one day

48 1 17 hrs. min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Cook

11. Industry or business

MOTHER FATHER

12. Name

Ethel Bassil

13. Birthplace

Va

14. Maiden name

Ennya Belle Jackson

15. Birthplace

Va.

16. Informant

Grace Ella Day

Address

430 E. Lombard St. Balt. Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

July 6, 1948
(month) (day) (year)

Cemetery or crematory

Jarvis Funeral Home

Location

1432 West 7th St. Washington

18. Funeral director

L. Lacoste Corp

Address

Hyattsville Md

19. Date rec'd by registrar

19

July 6, 1948 Amanda Downey

M. P. Bradstreet

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 6

1948 at 1:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..., to 19...

and that I last saw h... alive on 19...

Immediate cause of death

Cardiac Decompensation Sudden

Due to

Mitral Insufficiency 1 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE John J. Maloney M. D. or other

Address Chevyhgh- Md. Date signed 7-6-48

RECEIVED

JUL 10 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07457

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County 4534 Wheeler Rd. SE
 City or town Oxon Hill, Md. Prince Georges

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Solomon Beach

4. Sex

Male

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1893

6. (c) If alive, give age years

8. AGE: Years 55 Months - Days - If less than one day hrs. min.

9. Birthplace

Oxon Hill, Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

J P Beach

12. Name

MOTHER FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date

20. Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. Prince Georges

City or town

Oxon Hill

Street No.

Oxon Hill 4554 Wheeler Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

4554 Wheeler Rd.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 8 1948 at 11:45 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 25 1948 to July 8 1948

and that I last saw him alive on July 8 1948

Immediate cause of death

Pulmonary Edema

Due to

Hypertensive Cardio-
Renal Disease.

Due to

Hypertensive Cardio-
Renal Disease.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

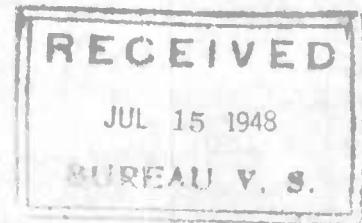
Means of injury Injured at work

23. SIGNATURE

J. Edwin Joyce M.D. or other

Address 2423 Nichols Drive Date signed July 8-48

E68
—
29
Bhbl



MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County Prince George's County

Village or City Bradbury Heights

596
7458

Registration Dist. No.

No. 5107 W St., S.E. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

ANNIE L.

(a) Residence: No. 5107 W St., S.E.

(Usual place of abode)

BEAVERS

St., Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
FEMALE	WHITE	WIDOWED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

THOMAS R. BEAVERS

6. DATE OF BIRTH (month, day, and year) SEP 13 1870

7. AGE	Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
	77			

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.	None
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.	
10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)
(State or country) Washington DC

13. NAME	George Augherton
14. BIRTHPLACE (city or town) (State or country)	Cow

15. MATURE NAME	Jones Style
16. BIRTHPLACE (city or town) (State or country)	Washington

17. INFORMANT (Address)	Charles L. Beavers
----------------------------	--------------------

18. BURIAL, CREMATION, OR REMOVAL Place	Bethel Cemetery Wed 7/14/48
--	-----------------------------

19. UNDERTAKER (Address)	W. W. Chambers Co.
-----------------------------	--------------------

20. FILED July 12, 1948	Carrie Campbell Registrar
----------------------------	------------------------------

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

JULY

(Month)

11

(Day)

1948
(Year)

22. I HEREBY CERTIFY That I attended deceased from SEPTEMBER, 1947, to SEPTEMBER, 1948.

I last saw her alive on JULY 9, 1948; death is said to have occurred on the date stated above, at 5:35 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

HYPERTROPHIC SEC	Date of onset
HYPERTROPHIC PNEUMONIA	JULY 9, 1948
HYPERTROPHIC ARTHRITIS	1944

Other Contributory Causes of importance:

Name of operation NONE Date of

What test confirmed diagnosis? Was there an autopsy? NO

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury _____, 19____

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed)	Ernest C. Cornelia	M. D.
(Address)	4400 Bowes Rd. S.E.	

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	Date of onset
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	Date of onset
	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07459
289

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

County.....

Prince Georges
Laurel

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

off + on since 1931

Hospital, institution, or street address where death occurred:

Laurel Sanitarium

How long in hospital or institution?

Oct. 4. 1939 to July 13 1948

3. (a) FULL NAME

Bixler, Jacob M.

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widower

6.(b) Name of husband or wife

Margaret (deceased)

7. Birth date of

deceased (mo., day, yr.)

Dec. 20. 1869

6.(c) If alive, give age..... years

8. AGE:

Years
78Months
6Days
24

It less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

Carroll Co. Md.

10. Usual occupation

Internal Rev. Whiskey Drager

Storekeeper

11. Industry or business

Noah Bixler

12. Name

Mother Father

Arthur De Hoff

13. Birthplace

State

Maryland

14. Maiden name

Mother

Susan Wheeler

15. Birthplace

State

Maryland

16. Informant

Address

Mrs. J. Arthur De Hoff

WINDSOR COURT Apts.

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof.....
(month) (day) (year)

Cemetery or cemetery

Location

MT. CARMEL CEMT

BALTO. CO. MD

18. Funeral director

Address

Wm. T. Tidewater & Sons

BALTO. MD

19. (Date rec'd by registrar)

19.

7/15 1948 Dr. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

PRINCE GEORGE

City or town.....

LAUREL

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

WASH. BLVD.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

No

3. (b) Social Security Number

No

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 13

19. 48 21 11. 45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 3

19. 48

to July 13 19. 48

and that I last saw him alive on July 13 19. 48

Immediate cause of death..... Myocardial failure DURATION

7 days

Due to..... Senility

Several

Due to.....

years

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

J. F. Robinson, M.D.

M. D. or other

Address..... Laurel Sanitarium Date signed July 15 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170 C

07460

CERTIFICATE OF DEATH

Reg. Dist. No. 2231

MARGIN RESERVED FOR BINDING

Line correctly

and legibly

1. PLACE OF DEATH:

County Prince George

City or town Cheverly Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 hr 24 min

Hospital, institution, or street address where death occurred:

Prince George General Hospital

How long in hospital or institution? 9 hr 24 min

3. (a) FULL NAME

Julius Block

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

m Jewish married

6.(b) Name of husband or wife LENORE Block

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years Months Days If less than one day
39 hrs. min.

9. Birthplace Norfolk Va

(Town, county, and state)

10. Usual occupation SCRAP IRON BUSINESS

11. Industry or business

12. Name Nathan Block

13. Birthplace Norfolk, Va

14. Maiden name Rachel Kiermer

15. Birthplace Va

16. Informant Mrs. H. M. A. Block

Address 741-Shirley Ave

Norfolk, Va

17. Burial Date thereof July 19, 1948

(Burial, cremation, or removal; Which?)

Cemetery or crematory Norfolk Va.

Location Oliver's Funeral Home

J. William Peay Son Co.

18. Funeral director

Address 300 - 4th St. N.E. Washington D.C.

19. Date record by registrar

Amanda Rooney

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State VIRGINIA County NORFOLK

City or town NORFOLK, VIRGINIA

(If outside city or town limits, write RURAL and give nearest town)

Street No. 830 Maury Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-18-48 1948 at 7⁰⁷ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Inflammation of brain stem

Due to Head injury in automobile accident

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of 7-17-48

Where did injury occur

(City or town) P.S. (County) (State)

Injured at home, farm, industry, public place

Means of injury

Reputed medical cause

23. SIGNATURE

M. D. Father

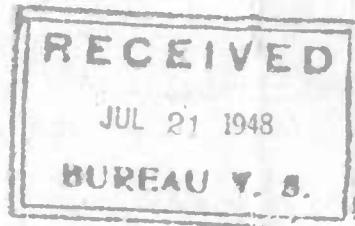
Address

Date signed 7-18-48

1909

39

8761



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07461
13+

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH: Prince Georges
 County.....
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 11 yrs., 9 mos., 19 days.
 Hospital, institution, or street address where death occurred:.....
 Glenn Dale Sanatorium
 How long in hospital or institution?..... 11 yrs., 9 mos., 19 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 631 Maryland Avenue, N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

MARY BONI

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife..... Thomas Boni

7. Birth date of deceased (mo., day, yr.)..... June 21, 1897

8. AGE:	Years	Months	Days	11 less than one day
	51	1	9	hrs. min.

9. Birthplace..... Washington, D. C.
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

MOTHER FATHER	12. Name	Anthony Tassa
	13. Birthplace	? Italy

MOTHER FATHER	14. Maiden name	Rose Campana
	15. Birthplace	? Italy

16. Informant..... Deceased

Address.....

17. Removal..... Date thereof..... July 31, 1948
 (Burial, cremation, or removal. Which?)

Cemetery or crematory..... Washington, D.C.

Location..... W.W. Chambers Co.

18. Funeral director..... Washington, D.C.

Address.....

19. Date rec'd by registrar..... 7-31-1948

Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 30, 1948, at 9 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Oct. 10, 1936, to July 30, 1948,
 and that I last saw her alive on July 30, 1948.

Immediate cause of death..... Pulmonary Tuberculosis

DURATION

26 yrs

Complications: -
 Bronchiectasis (tuberculous) 10 yrs
 Pulmonary fibrosis + emphysema

10 yrs

Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings or operations..... Date of op.

Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Finegan M.D.

M. D. or other

Address..... Glen Dale, Md. Date signed..... 7/30/48

RECEIVED

AUG 9 1948

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

07462

Evidence for change of age and birth date shown on:
FILE NO. G 11, AUG 30 1948 CERTIFICATE OF DEATH

Reg. Dist. No. *Dist*

Reg. dist 240

1. PLACE OF DEATH:

County.....

City or town.....

P. George
Brandywine R. F.D.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

McLain Booth

4. Sex

M

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....

Ida Booth

7. Birth date of deceased (mo., day, yr.)

Dec. 20, 1877

6. (c) If alive, give age ... 70? years

8. AGE:

84

Years

Months

Days

If less than one day

*7/4**7**8**.hrs.**min.*

9. Birthplace.....

Brandywine

(Town, county and state)

10. Usual occupation.....

11. Industry or business

12. Name.....

13. Birthplace

14. Maiden name.....

15. Birthplace

16. Informant.....

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)
7/31/48

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address

19. Date rec'd by registrar.....

19.

(Date rec'd by registrar)

19.

19.

19.

Registrar

8-2 - 48 7-29-1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Md.

County.....

Brandywine

Street No.....

R. F.D.

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 28 1948 at 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

19.....

and that I last saw h.....alive on.....

19.....

Immediate cause of death.....

Abscission

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Edwin L. Jane Jr.

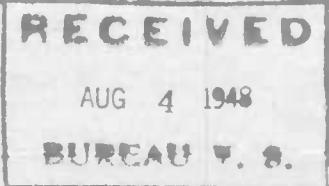
M. D. or other

Address.....

Waldorf Md.

Date signed.....

7-29-1948



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

113

07463
231

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Prince Georges
County Cleveland

City or town (if outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred

Prince Georges Hosp

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince George

City or town Riverdale (If outside city or town limits, write RURAL and give nearest town)

Street No. 5901 Cleveland Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mr. Bowie Bowie

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Sadie H. Bowie

7. Birth date of deceased (mo. day, yr.) Feb 5, 1879

8. AGE: Years Months Days It less than one day

69 hrs. min.

9. Birthplace Washington DC

(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Leonard O. Bowie

MOTHER FATHER 12. Name Rand

13. Birthplace Belmenia Illino

14. Maiden name Washington Ill.

15. Birthplace Washington Ill.

16. Informant Leon Bowie

Address University Park Md

Burials Glenwood

Date thereof July 15, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory Washington Ill.

Location Washington Ill.

18. Funeral director L. Loschi Sona

Address Hyattsville Md

19. Date rec'd by registrar 7/14/48 Amandah Dorsey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 July 1948 al 1 50% M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6:30 1948 to 7-13 1948

and that I last saw him alive on 7-12 1948

Immediate cause of death Spontaneous

Intrusive Pneumothorax

(Right) with Shock

Due to Emphysema with Blood

Formation 2 Pneumonia attacks

over past 3 weeks

DURATION

20 min.

(Clot)

3 hrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.B. Morris M.D.

M. D. or other

Address Mt. Rainier Md Date signed 7-14-48

RECEIVED

JUL 19 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316

07478

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges

City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 hours

Hospital, institution, or street address where death occurred:

Prince Georges Hospital

How long in hospital or Institution? 8 hours

3. (a) FULL NAME

Brown, Mr. Ernest

4. Sex

W. Married

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Agusta

7. Birth date of deceased (mo., day, yr.)

Jul 2, 1877?

6.(c) If alive, give age years

8. AGE:

Years 71? Months Days If less than one day hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Produce Merchant

Eastern Market

11. Industry or business

Overfield Brown

12. Name

Kate Rhodes

13. Birthplace

Md

14. Maiden name

Mrs. Warren Brown

15. Birthplace

Md

16. Informant

111 N. Gilmore St., Arlington Va

Address

Burial

Date thereof July 10, 1948

(Burial, cremation, or removal, which?)

(Month) (day) (year)

Cemetery or crematory

Prospect Hill

Washington D.C.

Location

L Gache Song

Lyattsville Md.

18. Funeral director

Amanda Dourney

Address

9/10 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince Geor-ge

City or town Edmonston

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4900-79th Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 7 1948 at 10:35 AM

July 4 1948 to July 7 1948

and that I last saw him alive on July 7 1948

Immediate cause of death

Uremia

3 days

Due to chronic Glomerular Nephritis

1 year

Due to

Other conditions Bronchopneumonia

2 days

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

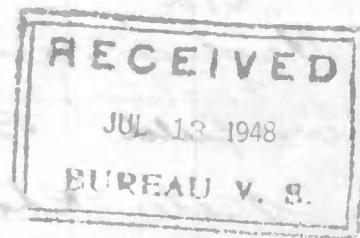
Means of injury Injured at work?

23. SIGNATURE

Samuel J. N. Siegel M.D.

4300 Maywood Drive M.D. Date signed July 8 1948

Address Mr. Siegel M.D.



I

~~PLEASE WRITE PLAINLY, WITH UNFADING INK.~~ Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

102

07464

CERTIFICATE OF DEATH

245

Reg. Dist. No.

1. PLACE OF DEATH:
 County Prince George
 City or town Rural, Hyattsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 weeks
 Hospital, Institution, or street address where death occurred:
 Mother Jones Rest Home
 How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Chevy Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4807 Leland St.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME
 Margaret Cole Buckley

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1876

8. AGE: Years	Months	Days	If less than one day
71	7	13	hrs. min.

9. Birthplace Washington, D.C.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

MOTHER FATHER 12. Name James Cole

13. Birthplace Ireland

14. Maiden name Margaret Cohan

15. Birthplace Ireland

16. Informant Miss Margaret J. Buckley

Address 4807 Leland St. Chevy Chase, Md.

17. Burial Date thereof July 28, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Washington, D.C.

18. Funeral director Warner E. Lumpsherry, Inc.

Address 8434 Ga. Ave. Silver Spring, Md.

19. (Date rec'd by registrar) July 27, 1948
 Registrar J. James Berry

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24th 1948 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19, 37, to July 1948, and that I last saw her alive on July 23, 1948.

Immediate cause of death Uremia, underlying cause Chronic Hypertension

Due to.....

Due to.....

Other conditions Chronic Hypertension

(Include pregnancy within 3 months of death) 20 yrs

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

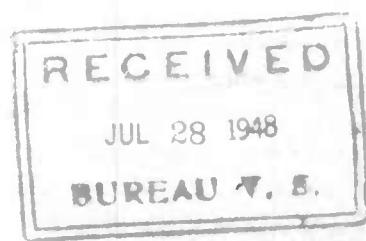
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE J. James Berry

M. D. or other

Address 8016 Georgetown Rd. Date signed 7/26/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *138**U72863*

1. PLACE OF DEATH: Prince Georges
 County.....
 City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 mos., 13 days
 Hospital, institution, or street address where death occurred:..... Glenn Dale Sanatorium
 How long in hospital or institution?..... 3 mos., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D. C. County.....
 City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
 Street No. 316 Broad Court, S. W.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

EVA C HASE (WOOD)

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife..... Perry Chase

7. Birth date of deceased (mo., day, yr.)..... April 29, 1903

8. AGE: Years	Months	Days	If less than one day
45	45	3	1
			hrs. min.

9. Birthplace..... Washington, D. C.
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... ---

MOTHER FATHER	12. Name..... Charles Wood
	13. Birthplace ? Maryland

MOTHER	14. Maiden name..... Mary Diggs
	15. Birthplace ? Maryland

16. Informant..... Deceased

Address.....

17. *removal*..... Date thereof..... July 31, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location..... Washington, D.C.

18. Funeral director..... Eugene Ford
 Address 1213 - 4th St., S. W., Washington, D.C.

19. ? - 31 - 1948 Rowlands Phillips
(Date rec'd by registrar)

3.(b) Social Security Number
 - - -

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 30, 1948 at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 16, 1948 to July 30, 1948
 and that I last saw her alive on July 30, 1948

Immediate cause of death..... Pulmonary Tuberculosis DURATION
 7 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

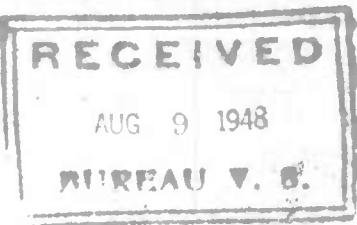
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Pinson, M.D.

M. D. or other.....

Address..... Glenn Dale, Md. Date signed..... 7/30/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136

07466

243

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Prince Georges
County.....Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 11 mos., 9 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 11 mos., 9 days

3.(a) FULL NAME

CLARK, VIVIAN

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife Clayton Clark, Sr.,

7. Birth date of deceased (mo., day, yr.) February 27, 1916
6.(c) If alive, give age 30 years8. AGE: Year Months Days If less than one day
32 32 4 6 hrs. min.B. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business - - -

12. Name John Petz

13. Birthplace Baltimore, Maryland

14. Maiden name Vinda Phillips

15. Birthplace Lauray, Virginia

16. Informant Deceased

Address Burial

17. (Burial, cremation, or removal. Which?) Date thereof July 7, 1948
(month) (day) (year)

Cemetery or crematory Ailington National Cemetery

Location Ailington Va.

18. Funeral director S.H. Funeral Co.

Address 2901 14th St. N.W.

19. Date rec'd by registrar July 3, 1948 Rowland S. Phillips
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

D. C. County.....

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 51 You Street, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 3, 1948 at 11:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/23 1946 to 7/3 1948

and that I last saw h d alive on 7/3

1948

Immediate cause of death

pulmonary tuberculosis 2 yrs. DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causee, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinucane M.D.

M. D. or other

Glen Dale, Md. Date signed 7/3/48

RECEIVED

JUL 16 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07467

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH: PRINCE GEORGES
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince GEORGES
City or town Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

3. (a) FULL NAME

GEORGE HENRY COBURN

3. (b) Social Security Number

4. Sex M 5. Color or race W MARRIED
6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife ANNA L. COBURN

7. Birth date of deceased (mo., day, yr.) July 29, 1881

8. AGE: Years 66 Months 11 Days 15 If less than one day
hrs. min.9. Birthplace STRANRAN N. CAR.
(Town, county, and state)

10. Usual occupation RETIRED GOVT EMPLOYEE

11. Industry or business U.S. GOVT

12. Name SIDNEY COBURN

13. Birthplace N. CAR

14. Maiden name Sophia William-ton

15. Birthplace N. CAR

16. Informant Mrs Anna L. COBURN

Address Bowie, Md.

17. Burial Date thereof July 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory FT. LINCOLN CEMETERY

Location BRADFORDSBURG RD. AT D.C. LINE

18. Funeral director J. G. Hobbs

Address 515 Washington Blvd Laurel, Md.

19. Date rec'd by registrar July 14, 1948 Recd. by Anna Lingling

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1948 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Rockville, Md., July 14, 1948, to July 14, 1948, and that I last saw him alive on July 14, 1948.

Immediate cause of death Coronary thrombosis DURATION 5 mos

Due to Arteriosclerosis 5 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. W. Marley M.D.

M. D. or other

Address Laurel, Md. Date signed July 14, 1948

RECEIVED
JUL 16 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07468

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH: Prince Georges
 County.....
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 mos., 23 days.
 Hospital, institution, or street address where death occurred:..... Glenn Dale Sanatorium
 How long in hospital or institution?..... 2 mos., 23 days.

3. (a) FULL NAME

LEONARD COOLEY

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife..... Lillian L. Cooley

7. Birth date of deceased (mo., day, yr.)..... June 16, 1891

6.(c) If alive, give age..... 50 years

8. AGE: Years	Months	Days	If less than one day
57	57	1	7 hrs. min.

9. Birthplace..... Washington, D. C.

Inter (Town, county, and state)

10. Usual occupation..... state Commerce Co., Passenger Traffic Branch Traffic

11. Industry or business

12. Name..... Richard C. Cooley

13. Birthplace..... Rockville, Maryland

14. Maiden name..... Harriet Mast

15. Birthplace..... Springfield, Ohio

16. Informant..... Deceased

Address

17. Burial Date thereof..... July 27, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Fort Meade Cemetery

Location..... Prince George's County, Md.

18. Funeral director..... The J. T. Jones Co.

Address..... 2901 - 14th N.W.

19. Date rec'd by registrar..... July 27, 1948

(Date rec'd by registrar) Registrars

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... D. C.	County.....
City or town..... Washington	(If outside city or town limits, write RURAL and give nearest town)
Street No...... 5939 Utah Avenue, N. W.	(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... JULY 23, 1948, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 29, 1948, to JULY 23, 1948, and that I last saw him alive on JULY 23, 1948.

Immediate cause of death..... Syphilis Heart Disease

DURATION

unknown

Due to..... Pulmonary Tuberculosis

2 yr.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

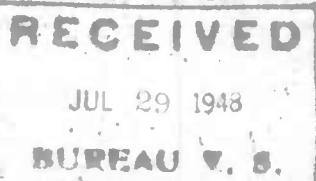
Injured at home, farm, industry, pub'l'c place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel P. Giaccone, M.D.

M. D. or other

Address..... Glen Dale, Md., Date signed..... 7-23-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07469
136

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

Prince Georges

County.....

Glenn Dale, Maryland

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 mos., 7 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 5 mos., 7 days

3. (a) FULL NAME

CRAWFORD, ALVIN

4. Sex

Male

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

-

7. Birth date of deceased (mo., day, yr.)

April 8, 1923

6.(c) If alive, give age

years

8. AGE:

Years

25

Months

25

Days

3

If less than one day

10

hrs.

min.

9. Birthplace

Aberdeen, Mississippi

(Town, county, and state)

Messenger

10. Usual occupation

11. Industry or business

FATHER

12. Name

Benjamin Crawford

MOTHER

13. Birthplace

Aberdeen, Mississippi

14. Maiden name

Mary Simms

15. Birthplace

Aberdeen, Mississippi

16. Informant

Deceased

Address

Removal

(Burial, cremation, or removal. Which?)

Date thereof July 20/48

Cemetery or crematory

Location

8 Washington D.C.

M. L. Phillips

Address

Preston St. 771

July 20, 1948 Rowland S. Phillips

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D. C.

County

City or town

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1440 W. Street, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

579-20-7861

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 18, 1948 at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/10 1948 to 7/18 1948

and that I last saw him alive on 7/18 1948

Immediate cause of death

pulmonary tuberculosis

DURATION

5 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causee, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

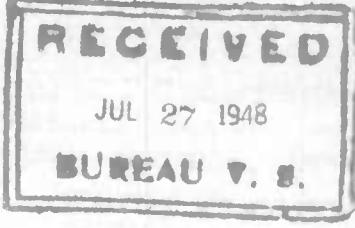
23. SIGNATURE

Daniel Leo Pinicane M.D.

M. D. or other

Glenn Dale, Md. Date signed 7/18/48

Address



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07471
231
Reg. Dist. No.

MARGIN RESERVED FOR BINDING
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County *Prince George's*
 City or town *Bladensburg*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *3 years*

Hospital, Institution, or street address where death occurred:
5303 - Gallatin St.

How long in hospital or institution?

3. (a) FULL NAME

Margorie Blas Critzer
 4. Sex *F.* 5. Color or race *W.* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *June 7, 1881* 6. (c) If alive, give age years

8. AGE: Years *67* Months *1* Days *13* If less than one day hrs. min.

9. Birthplace *Augusta County, Va*
 (Town, county, and state)

10. Usual occupation. *None*

11. Industry or business

12. Name *John F. Parrish*
 MOTHER FATHER

13. Birthplace *Va*
 14. Maiden name *Clytia Douglas Dylan*

15. Birthplace *Va.*
 16. Informant *Mrs. George Stuart*

Address *Hyattsville, Md*
 17. Removal *Removal* Date thereof *July 20, 1948*
 (Burial, cremation, or removal, W/tch?) (month) (day) (year)

Cemetery or crematory *Harringtonburg*
 Location *Va*

18. Funeral director *J. Gasch's Son*
 Address *Hyattsville, Md*

19. *7/20 1948* *Amanda Howey* *Registrar*
 (Date rec'd by registrar) *7-20-48* *John J. O'Galway, D.M.D.* *Domino*
 Address *Hyattsville, Md* *deep med.*
 Means of injury *Injured at work?* *Injured at work?*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State *Maryland* County *Prince George's*
 City or town *Bladensburg*
 Street No. *5303 - Gallatin St.*
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 20* 1948 at *9:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to. 19.

and that I last saw h. alive on. 19.

Immediate cause of death

Arterio-sclerotic heart disease

Due to.

Due to.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE. *John J. O'Galway, D.M.D.* *Domino*
 M.D. *other*
 Address *Hyattsville, Md* Date signed *7-20-48*

RECEIVED

JUL 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK.
is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13b

CERTIFICATE OF DEATH

Reg. Dist. No. 171243

1. PLACE OF DEATH:

Prince Georges

County.....

Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos., 2 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 4 mos., 2 days

3. (a) FULL NAME

KATHERINE DABNEY

4. Sex

Female | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Shepherd B. Dabney

7. Birth date of deceased (mo., day, yr.) April 12, 1879

8. AGE: Years 69 Months 69 Days 3 If less than one day 9 hrs. min.

8. Birthplace Brooke, Virginia

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James Morton

13. Birthplace ? Virginia

14. Maiden name Martha Jones

15. Birthplace ? Virginia

16. Informant Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 21, 1948

(month) (day) (year)

Cemetery or crematory Washington, D.C.

Location

18. Funeral director Wm. J. Spally

Address 3200 R.R. Ave. S.E. Washington, D.C.

19. 7-21-1948 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

D. C.

County.....

City or town.....

Washington

Street No.....

4832 Kansas Avenue, N.W.

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war.....

3. (b) Social Security Number

- - -

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 21, 1948, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAR. 18, 1948, to JULY 21, 1948,

and that I last saw her alive on JULY 21, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

6 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

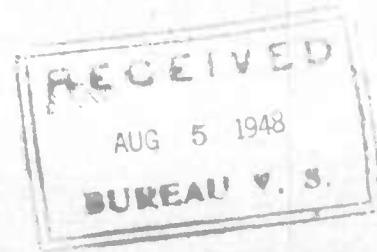
Means of injury

Injured at work?

23. SIGNATURE

Daniel Lee Pinson M.D. M. D. or other

Address 4832 Kansas Avenue, N.W. Date signed 7-21-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07472

CERTIFICATE OF DEATH

93d Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George General Hospital
 City or town Cheverly and Prince
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) 3 weeks

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. Md. County Prince George

City or town Lanham, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(e) IF VETERAN, NAME WAR

3. (a) FULL NAME

Franklin J. Davis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

May Davis

7. Birth date of deceased (mo. day, yr.)

Apr. 14 1877

(b) If alive, give age

8. AGE:

Years

Days

If less than one day

9. Birthplace

Pr. Bus Co Md

(Town, county, and state)

10. Usual occupation

Utility man

11. Industry or business

Turner Davis

12. Name

Maryland

13. Birthplace

Grace Lamar

14. Maiden name

Maryland

15. Birthplace

Mrs. Alvin Moreland

16. Informant

Lanham Md

Address

Buried July 7 1948

17. (Burial, cremation, or removal) White

(Month) (day) (year)

Cemetery or crematory

Baltimore

Location

Baltimore Md

18. Funeral director

Clarence Forester

Address

Woodlawn Md

19. (Date rec'd by registrar)

July 6 1948

Amanda Dickey

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH

7-5

1948, SA

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. m. alive on July 0 1948

Immediate cause of death

myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

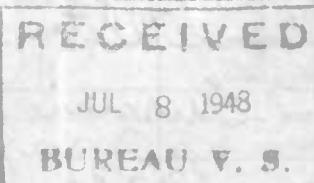
Leonard Davis

Address Hyattsville Md

M. D. or other

Date signed 7-6-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CO 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07473

Reg. Dist. No. 214

93d

1. PLACE OF DEATH:

County Prince George
 City or town Lakewood Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

45 Taylor Ave

How long in hospital or institution?

3. (a) FULL NAME

NATHAN DAVIS

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced W

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 1870 6.(c) If alive, give age _____ years8. AGE: Years 78 Months 8 Days 1 If less than one day
hrs. 0 min. 09. Birthplace Unknown Russia
(Town, county, and state)10. Usual occupation Pensioner

11. Industry or business

12. Name Frank Davis13. Birthplace Franklin14. Maiden name Eliza ?15. Birthplace Unknown Russia16. Informant Mrs Anna SlegersAddress Cleveland, Ohio17. (Burial, cremation, or removal, Which?) Burial Date thereof July 4-48
(month) (day) (year)Cemetery or crematory Heber Burial SocietyLocation Cottage Street Hill18. Funeral director B. Van Gansby & SonAddress 3501 - 14th St. S.W.19. July 4, 1948 Josephine Schoeller
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince GeorgeCity or town Lakewood Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 45 Taylor Ave
(If rural, give LOCATION)

2.(a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1948 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 4 1948 to July 4 1948 and that I last saw him alive on July 4 1948

Immediate cause of death

Myocardial failureDue to Hypertensive CardiacVascular disease

Due to

Other conditions ArterioscleroticGangrene of toes (amputations)
(Include pregnancy within 8 months of death)

Major findings or operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

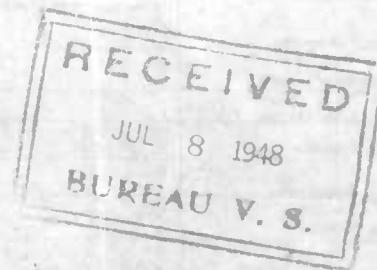
Injured at work?

23. SIGNATURE Dana F. Patterson, M.D.

M. D. or other

Address 9500 Lee St. Silver Spring Md. Date signed 7/4/48

1948
1948
1948



PLEASE WRITE PLAINLY, WITH
CONFADING INK. Supply every item of information carefully.
The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

45C

07474

CERTIFICATE OF DEATH

Reg. Distr. No. 237

1. PLACE OF DEATH

County.....

City or town.....

AQUASCO PH. GEORGE'S
AQUASCO

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

GEORGE OLIVER DEMARK

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

MARY MADGE DEMARK -
(NEE) GREENWELL

7. Birth date of deceased (mo., day, yr.)

Oct. 9, 1865

6. (c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day
82 9 16

hrs.

min.

9. Birthplace.....

Chesapeake, Md.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

Thomas Demark

12. Name.....

MOTHER FATHER

13. Birthplace

AQUASCO, MD

14. Maiden name.....

Elizabeth Robertson

15. Birthplace

AQUASCO, MD.

16. Informant.....

Earl H. Demark

Address

607 Savannah St. S.E.

17. (Burial, cremation, or removal. Which?)

Funeral

Date thereof.....
(month) (day) (year)
7/23/48

Cemetery or crematory.....

Glenwood

Location.....

Washington, D.C.

18. Funeral director.....

Hurst & Ryerson

Address

Waelder, Md.

19. (Date rec'd by registrar)

19.....
M. L. Monroe
per T. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md. Ph. George

County.....

AQUASCO

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 25 1948 at 9:35 P.M.

May 1946 to July 25 1948

and that I last saw him alive on March 21 1948

Immediate cause of death

Circulatory collapse & Cardiac failure

Due to arteriosclerosis

and

Due to carcinomatosis mouth & lungs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

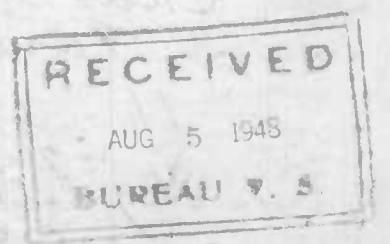
Means of injury Injured at work?

23. SIGNATURE

Alfred E. Lapan, M.D.

M. D. or other

Address Aguaasco, Md. Date signed July 26, 1948



Evidence for change of
age and birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07475

FILM NO. G 117 AUG 30 1948 CERTIFICATE OF DEATH

245

Reg. Dist. No.

1. PLACE OF DEATH:

County

Prince Georges

City or town

Riversdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

48

Hospital, Institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution?

48

3. (a) FULL NAME

Melia Hlevaney

4. Sex

5. Color or race

6. (a) Single, married, widowed or divorced

f

w

Married

6. (b) Name of husband or wife

Michael Hlevaney

deceased

7. Birth date of
deceased (mo., day, yr.)

Oct. 2 1888 1878

6. (c) If alive, give age.....years

8. AGE:

Years
69

Months
16/157

Days
9

If less than one day
27

hrs.
min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER FATHER

12. Name James Gallagher

13. Birthplace Ireland

14. Maiden name Mary Shields

15. Birthplace Ireland

16. Informant Joseph O'Neill son-in-law

Address 144 P Ridge Rd Greenbelt

17. Transportation

Date thereof July 31, 1948

18. Burial, cremation, or removal. Which?

(month) (day) (year)

Cemetery or crematory

Saints Cross

Philadelphia Pa

Location F Gasch's Sons

19. Funeral director

Address Hyattsville Md.

20. Date rec'd by registrar

July 30, 1948 Mrs. Jas. Severe

Signature

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MD

County

Prince Georges

City or town

Greenbelt

(If outside city or town limits, write RURAL and give nearest town)

Street No.

144

P. Ridge Road

(If rural, give LOCATION)

2. (a) If veteran, name war

?

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 29

19

48

10

AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 21

19

48

10

JULY 29,

19

48

and that I last saw her alive on July 29,

19

48

Immediate cause of death

Cerebrovascular accident.

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

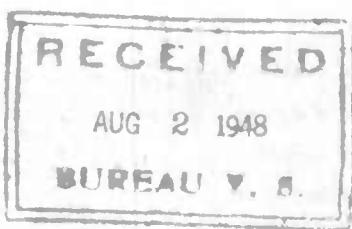
Injured at work?

23. SIGNATURE

Address

Reed A. Greenbelt, Md. Date signed

1948



Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

ADM No. G 116 AUG 13 1948 CERTIFICATE OF DEATH

07476

Reg. Dist. No. 239

1. PLACE OF DEATH:

County

City or town

Geo. Co.

Laurel, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Warren's Hosp. Laurel, Md.

How long in hospital or institution?

14 days

3. (a) FULL NAME

William Morgan Dotson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

m

w.

married

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

Nov. 28, 1905

8. AGE: Years

Months

Days

If less than one day

42 11 3 9 26 hrs. min.

9. Birthplace

(Town, county, and state)

Wise Va

10. Usual occupation

Carpenter

11. Industry or business

William W G Dotson

MOTHER FATHER

12. Name

Marshall F Dotson

Va

13. Birthplace

Nannie Hillman

14. Maiden name

Nannie Hillman

Va

15. Birthplace

Marshall F Dotson

Elkridge, Md

Va

16. Informant

Burial

7-27-48

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Wash. Natl. Cemetery

Co.

Location

Seitland, Md.

Co.

18. Funeral director

WWG Bradens

Co.

Address

Riverdale, Md.

Co.

19. Date rec'd by registrar

July 24, 1948

Registrar

Address

M. Brashears

Co.

Signature

Amanda Rooney

Co.

Date signed

7/24/48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Geo. Co.

City or town

Beltsvillee

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 24, 1948, at 8:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 30, 1948, to July 24, 1948, and that I last saw him alive on July 24, 1948.

Immediate cause of death

Arterioles nephrosclerosis

Due to malignant hypertension

and cerebral edema

Other conditions

• calculus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Alured at work?

23. SIGNATURE

O. Stephens, M.D.

M. D. or other

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136

07477

243

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 4 mos., 4 days.

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 4 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C.

County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1109 - 9th St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

EALEY FRANCES L.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife..... Charles Ealey

6.(c) If alive, give age..... 31 years

7. Birth date of deceased (mo., day, yr.)..... April 6, 1920

8. AGE: Years Months Days If less than one day
28 28. 2 27 hrs. min.9. Birthplace..... Raleigh, North Carolina
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... ---

12. Name..... William Durant

13. Birthplace..... Timsville, South Carolina

14. Maiden name..... Gertrude Harrington

15. Birthplace..... Bamburg, South Carolina

16. Informant..... Deceased

Address.....

17. Removal to Wash. D.C. Date thereof..... July 3, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

18. Funeral director..... Robert S. Garrison

Address..... 1820 - 9th St., NW

19. (Date rec'd by registrar)

July 3, 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 3

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2/28 1948 to 7/3 1948
and that I last saw her alive on 7/3 1948

Immediate cause of death..... pulmonary tuberculosis

DURATION 7 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

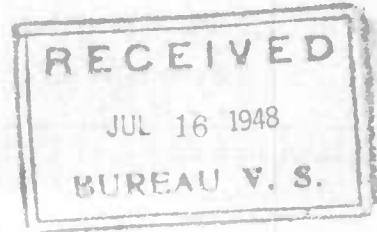
23. SIGNATURE..... Daniel Leo Finegan M.D.

M. D. or other

Address..... Glen Dale, Md.

Date signed.....

7/3/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. True correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136

CERTIFICATE OF DEATH

Reg. Dist. No.

243

1. PLACE OF DEATH:

Prince Georges

County.....

Glenn Dale, Maryland

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 yr., 1 mo., 12 days.....

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 1 yr., 1 mo., 12 days.....

3. (a) FULL NAME

MOTLEY MARGARET ETHEL

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Sepa rated

6.(b) Name of husband or wife.....

Robert Motley

7. Birth date of deceased (mo., day, yr.)

October 22, 1919

6.(c) If alive, give age..... 30 years

8. AGE: Years Months Days If less than one day

28 28 9 1 hrs. min.

9. Birthplace.....

(Town, county, and state)

Elevator Operator

10. Usual occupation

11. Industry or business

12. Name..... Emanuel Crosby

13. Birthplace ? South Carolina

14. Maiden name..... Lillian Coleman

15. Birthplace Washington, D. C.

16. Informant..... Deceased

17. Burial, cremation, or removal. Which? Removal to Wash. D.C.

Date thereof..... July 23, 1948

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director..... Jaeger Funeral

Address..... 389 - R. S. Ave. nw

19. Date rec'd by registrar..... July 23, 1948

Registrar..... Rowland & Phillips

Date signed..... 7/23/48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

D. C.

County.....

City or town.....

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1334 - 22nd St. S. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 23, 1948 at 12:05

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/10 1947 to 7/23 1948

and that I last saw her alive on

7/23 1948

Immediate cause of death.....

pulmonary tuberculosis

DURATION

13 mos

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

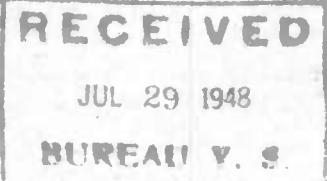
Means of injury.....

Injured at work?

23. SIGNATURE..... Daniel Leo Finucane M.D.

M. D. or other

Address..... Glenn Dale, Md. Date signed..... 7/23/48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07480

CERTIFICATE OF DEATH

245

Reg. Dist. No. 55e

1. PLACE OF DEATH:

County Prince George County

City or town Rosedale 2nd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 1/2 days

Hospital, institution, or street address where death occurred: Island Memorial Hospital

How long in hospital or institution? 29 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Greenbelt Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5A Parkway Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

Mr. Harry Lee Evans

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male white

6.(b) Name of husband or wife

Mrs. Lucille Evans

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo. day, yr.)

Sept 27 1889

8. AGE: Years

Months

Days

If less than one day

58

11

hrs.

min.

9. Birthplace

West Virginia

(Town, county and state)

10. Usual occupation

Painter

11. Industry or business

Martin & Evans

MOTHER FATHER

12. Name

Martin & Evans

13. Birthplace

Virginia

14. Maiden name

Ela & Evans

15. Birthplace

Virginia

16. Informant

Mrs. Lucille Evans (wife)

Address

5A Parkway Rd. Greenbelt Md

17. Burial

Date thereof Aug 2, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Lincoln Cemetery

Location

Prince Geor Co, Md

18. Funeral director

W W Chambers Co

Address

580 6-level mol Ave

19. July 23, 1948 James Berry

(Date recd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Greenbelt Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5A Parkway Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

30 July 1948 at 9:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

32 June 1948 to 30 July 1948

and that I last saw him alive on 7-30-48

19

Immediate cause of death

Cerebrovascular (Stroke)

DURATION

Due to immediate & habitual

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Occlusion - hepatic - severe

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

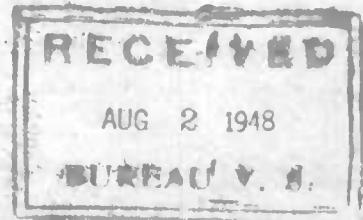
Means of injury

Injured at work?

23. SIGNATURE

Arthur Gaskins M. D. or other

Address Island Mem. Hosp Date signed 7-30-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1626

07481
239

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County

Prince George

City or town

Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since June 29 1948

Hospital, institution or street address where death occurred:

Laurel Sanitarium

How long in hospital or institution? 24 days

3. (a) FULL NAME

Mrs. Margaret Fiegenbaum

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 25 1860

8. AGE:

Years
88Months
0Days
20

If less than one day

hrs.

min.

9. Birthplace

Cambridge Iowa

(Town, county, and state)

10. Usual occupation

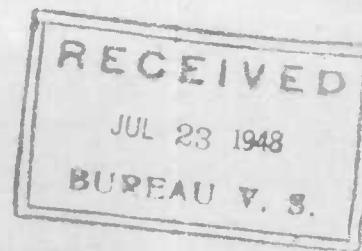
Housewife

11. Industry or business

A. McKee

FATHER

12. Name



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07482

CERTIFICATE OF DEATH

93d
245

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: *Pr. Geo. Co.*
 County: *Pr. Geo. Co.*

City or town: *Hyattsville*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *4 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Florence A. Fitzsimmons

4. Sex *M* 5. Color or race *W.* 6. (a) Single, married, widowed, or divorced *married*

6. (b) Name of husband or wife *Ralph. Fitzsimmons*

7. Birth date of deceased (mo., day, yr.) *Oct. 22-1892* 8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct. 22-1892* 8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct. 22-1892* 8. (c) If alive, give age years

8. AGE: Years *55* Months Days If less than one day hrs. min.

9. Birthplace *Somerville Mass* (Town, county, and state)

10. Usual occupation *Clerk U.S. Govt.*

11. Industry or business *Federal Security Agency*

12. Name *McKinney*

13. Birthplace *"*

14. Maiden name *"*

15. Birthplace *"*

16. Informant *Mrs. Mc Kinney*

Address *4507 Emerson St. Hyattsville*

Burial Date thereof *Burial* *7-30-48* (month) (day) (year)

Cemetery or crematory *Boston Cem. Mass*

Location *W.W. Branches Jr.*

18. Funeral director *W.W. Branches Jr.*

Address *Rivertown - Md.*

19. Date rec'd by registrar *July 28, 1948 James Berry*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Pr. Geo. Co.*City or town *Hyattsville*
 (If outside city or town limits, write RURAL and give nearest town)Street No. *4502-Emerson St.*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *7-27-48* 19 *545a*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Apr. 28* to *July 26*, 1948, and that I last saw him alive on *7-26*.Immediate cause of death *Myocardial Hypertension*DURATION *2 m*Due to *Myocardial Hypertension*Due to *Myocardial Hypertension*Other conditions

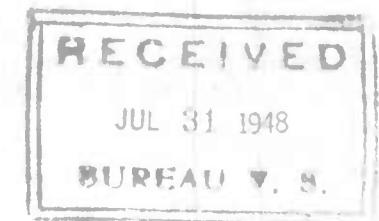
(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE *Jeanne Hay*M. D. or other *Neggs. MD*Address *7-27-48* Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07483
245

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

65 years

Hospital, institution, or street address where death occurred

Bellevue Memorial Hospital

How long in hospital or institution?.....

19 days.

3. (a) FULL NAME

GEORGE GASON GAYLOR

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

MARRIED

ANNIE GAYLOR

6. (b) Name of husband or wife

6. (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.)

13 Sept 1871

8. AGE:

Years 76 Months 10 Days 0

If less than one day hrs. 0 min.

9. Birthplace

HARROWS Anne Arundel Co.

(Town, county, and state)

10. Usual occupation

11. Industry or business

AND Builder

12. Name

JOHN COLUMBUS GAYLOR

13. Birthplace

Anne Arundel Co

14. Maiden name

MARY MARGARET ANDERSON

15. Birthplace

Anne Arundel Co

16. Informant

MARY G. GAYLOR

Address

4818 Branchville Rd - Branchville

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof, July 16, 1948

(month) (day) (year)

Cemetery or crematory

Fort Lincoln

Location

Bladensburg Road Maryland

18. Funeral director

W W Chambers Co.

Address

5801 Cleveland Ave Silverdale

19. Date rec'd by registrar

July 14 " 1948 Mrs. J. D. Severe

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND

County

City or town

BRANCHVILLE, MD

Street No.

4809 APACHE ST.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

13 July 48

20. DATE OF DEATH

JUNE 25 1948, to JULY 13 1948

and that I last saw him alive on 13 JULY 1948

Immediate cause of death
HEART DISEASE WITH
ARTERIOSCLEROSIS
AURICULAR FIBRILLATIONDue to
GENERALIZED ARTERIO-
SCLEROSIS

Due to

CEREBRAL THROMBOSIS
20 days

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

No operation

Date of op.

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

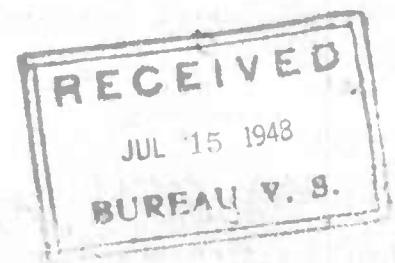
23. SIGNATURE

John E. Etienne

M. D.

7-13-48 Date signed

Address



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

17484

94a

CERTIFICATE OF DEATH

Reg. Dist. No.

239

1. PLACE OF DEATH:

County.....

Prince Georges

City or town.....

Gambrill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hours

Hospital, institution, or street address where death occurred:

Poplar Drn Tourists Camp

How long in hospital or institution?

3. (a) FULL NAME

Clarence B. Gilchrist

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

Married

6. (b) Name of husband or wife

Rebecca Gilchrist

7. Birth date of deceased (mo., day, yr.)

June 26, 1879

6. (c) If alive, give age 52 years

8. AGE:

Years

Months

Days

If less than one day

69

10

hrs.

min.

9. Birthplace

(Town, county, and state)

Bedford Pa.

10. Usual occupation

Retired Carpenter

11. Industry or business

John Christopher Gilchrist

12. Name

Bedford Pa.

13. Birthplace

Laura Beckershoff

14. Maiden name

Bedford Pa.

15. Birthplace

Russell Gilchrist

16. Informant

R. D. 2 - Wampum Ave. Elwood City
Transportation Date thereof 7/7/48 Pa.

17. Burial, cremation, or removal (Which?)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Canton

Ohio

Location

F. Gascha Sons

18. Funeral director

Mayhewville Md.

Address

M. Bechtel

19. (Date rec'd by registrar)

July 7 1948 Amanda Dowdy

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County Stark

City or town Canton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2212 Walthan Pl S. W. C. 2

(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 7

1948 at 12:03 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw h. alive on

19...

Immediate cause of death

Coronary Occlusion

Duration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Maloney, D.P.M. Esq.

M.D. or other

Cleveley Md.

Date signed 7-7-48

RECEIVED
JUL 10 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d
07485

CERTIFICATE OF DEATH

Reg. Dist. No. 272

1. PLACE OF DEATH:

County

Prince Georges Co.

City or town

Forestville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alexander Gray

4. Sex

Male

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Elijah Gross Gray

Deceased

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 7, 1878

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

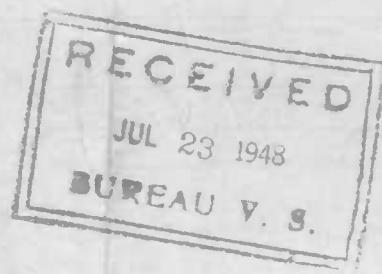
70 yrs

2 mo

18

hrs.

min.



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07486

135a

H.M. No. G 1 AUG 2 - 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's

City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 4 days

3. (a) FULL NAME

Irene Gray

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female w widowed

6.(b) Name of husband or wife

Benjamin Gray

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age years

Oct 12, 1886

8. AGE: Years Months Days If less than one day hrs. min.

61-62 9 11

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation

Loverwife

11. Industry or business

MOTHER FATHER Benjamin Granwell

12. Name Washington, D. C.

13. Birthplace Washington, D. C.

14. Maiden name Mary Harrigan

15. Birthplace Washington, D. C.

16. Informant Mrs. Katherine White

Address Riverdale, Md.

Burial

(Burial, cremation, or removal. Which?)

Date thereof 7/27/48

Cemetery or crematory The Lincoln

Location Colmar Manor, Md.

18. Funeral director

F. Kosciusko Son

Address Hyattsville, Md.

19. (Date record by registrar)

7/27 1948 Amanda Dauney

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4629 Baltimore Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

7-23 1948 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-19 1948 to 7-23 1948

and that I last saw her alive on

7-23 1948

Immediate cause of death

Surgical shock

DURATION

3 days

Due to Prepartum Obstruction : For

relief of intractable pain

Due to Hypochondriasis

Other conditions Hypertension Cardiovascular disease

Kyphosis

1 year

Thrombocytopenia & edema

1 year

Major findings of operations Prepartum Obstruction

Date of op. 7-26-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

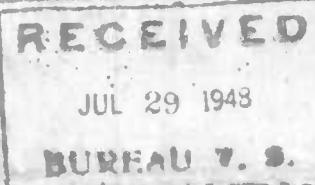
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Murphy, M.D.

M. D. or other

Address 911 Rockville Rd. Date signed 7-24-48



PLEASE WRITE PLAINLY. WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07487

159

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

Prince Georges

County

Avery

City or town

(if outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 day

Hospital, institution, or street address where death occurred:

Prince Georges Hospital

How long in hospital or institution?

1 day

3. (a) FULL NAME

Baby Girl Greathouse (Twins)

4. Sex

Female

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 26, 1948

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

F. G. Greathouse

Kentucky

Henrietta Dean

Md.

16. Informant

Mrs. Henrietta Greathouse

Gambles, Md

Address

Cremation

Date thereof 7/31/48

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Prince George's General Hospital

Cheverly, Md.

Location

A. T. Beale, Superintendent

Cheverly, Md.

Address

18. Funeral director

A. T. Beale, Superintendent

Cheverly, Md.

Address

19. (Date rec'd by registrar)

1948

Date signed

Amanda Dow

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Anne Arundel

City or town

Gambrills

(if outside city or town limits, write RURAL and give nearest town)

Street No.

Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

27 July

19

48 at 7 1/2 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

19.

and that I last saw him alive on

Immediate cause of death

Due to IMMATURITY

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

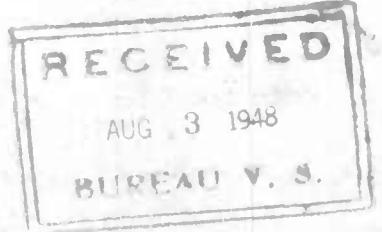
Signature

M. D. or other

Address

Date signed

7/27/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07488

242

Reg. Dist. No. 93d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Prince George's
County Maryland
 City or town. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 For newborn infants give residence of mother
Prince George's County Maryland
 City or town. (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME John T. Hamilton
 4. Sex Male 5. Color or race Colored 6. (c) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Louisa Hicks

7. Birth date of deceased (mo., day, yr.) Aprn. 1869 6. (c) If alive, give age years

8. AGE: Years 81 Months Days If less than one day hrs. min.

9. Birthplace Prince George's Co., Md. (Town, county and state)

10. Usual occupation Laborer Retired

11. Industry or business P.S. Govt. Printing Office

12. Name David Hamilton

13. Birthplace Prince George's Co., Md.

14. Maiden name Hattie Hamilton

15. Birthplace Prince George's Co., Md.

16. Informant Josephine Hamilton
 Address Baltimore, Md.

17. Burial Date thereof Aug 2, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Mt. Olivet Cemetery

Location Washington, D.C.

18. Funeral director Robert L. McGuire
 Address 1820-9 St., N.W. Wash. D.C.

19. July 30, 1948. (Date rec'd by registrar) Carrie T. Campbell
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1948 at 3:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1945 to July 30, 1948 and that I last saw him alive on July 30, 1948.

Immediate cause of death Hypertension
Cardio-vascular Disease

Due to Hypertension
Chronic multiple
Osteitis, Arterio-
Sclerosis,

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings or operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

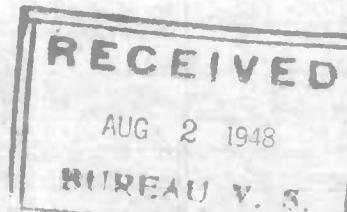
Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work? _____

23. SIGNATURE J. L. Beldon, M.D.
 M. D. or other _____
 Address XV2-3-Hux D. K. H. July 30, 1948
 Date signed July 30, 1948

RECEIVED TO THE STATE CHARTER

HTD TO STATEMENT



Evidence for change of
A G E shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 116 AUG 4 - 1948 CERTIFICATE OF DEATH

1246

07484

245

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Prince George's
Riverdale Md

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Frank Lungford Harrison

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Divorced

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)

6. (c) If alive, give age..... years

sept 1, 1906

8. AGE:

Years

Months

Days

If less than one day

42

41

10

3

hrs. min.

9. Birthplace

Bettsville Md

(Town, county, and state)

10. Usual occupation

Carpenter

Helper

11. Industry or business

George Harrison

MOTHER FATHER

12. Name

Mary

Harrison

13. Birthplace

Md

Marysteph

14. Maiden name

Md

Marysteph

15. Birthplace

16. Informant

John K. Harrison

Address

4015 - Kennedy St. Hyattsville Md

Burial

Date thereof

July 6, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Et Lincoln

Location

Colmar Manor Md

18. Funeral director

F. Lassche sons

Address

Hyattsville Md

19. Date rec'd by registrar

July 5, 1948

Mrs. J. S. Severe

Deputy Coroner

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md Pro Geo

City or town.....

Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 4 1948 at 7:8 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to.....

19.....

and that I last saw h..... alive on.....

Immediate cause of death.....

Influenza, crouposis -
Sore Throat - Edema of brain

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

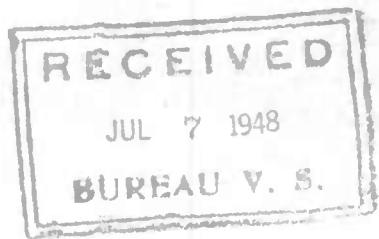
23. SIGNATURE.....

John J. Maloney Esq.
2100 Cherry Hill Rd. Date signed 7-5-48

M. D. or other

Address.....

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07490
134a

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince George
City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred

Prince Georges General Hosp. Tid.How long in hospital or institution? 14 days

3. (a) FULL NAME

Havener, Mr. John Leon4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Florence Bertha Havener7. Birth date of deceased (mo., day, yr.) Nov. 4 6. (c) If alive, give age 1878 years8. AGE: Years 68 Months Days If less than one day hrs. min. 9. Birthplace Suffolk City Maryland
(Town, county, and state)10. Usual occupation Cabinet Maker Retired11. Industry or business U.S. Post office12. Name Benjamin Havener13. Birthplace Unknown14. Maiden name Elizabeth Gray15. Birthplace Maryland16. Informant Florence B. HavenerAddress 5477 Spring St, Forestville, Md.17. Burial Burial Date thereof July 14 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CemeteryLocation Prince George County, Md.18. Funeral director Dr. E. L. S. LymanAddress 517 11th St., S.E., Wash. D.C.19. July 13 1948 Carrier Campbell
(Date rec'd by registrar) Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State Md. County Po.City or town Washington 19
(If outside city or town limits, write RURAL and give nearest town)Street No. 5477 Spring St.
(If rural, give LOCATION)2.(a) If veteran, name war None3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1948 at 11¹⁰ P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 1948 to July 10 1948, and that I last saw him alive on July 10 1948.Immediate cause of death Urinary & Genital Report Report DURATION 3-4 weeksDue to Pyelonephritis - bilateral Several yearsDue to Pyelonephritis - bilateral Several yearsOther conditions (Include pregnancy within 3 months of death)Major findings or operations Renal calculus - left
suprapubic pyelonephritis - left July 6, 1948Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

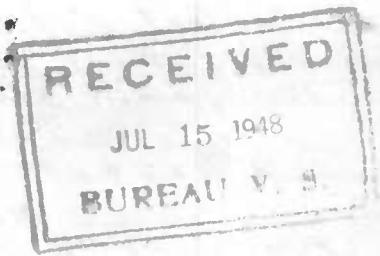
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of injury Injured at work?

23. SIGNATURE James M. Fawcett M. D. or otherAddress 1835 Eye Street Date signed July 13 '48



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07491

230

CERTIFICATE OF DEATH

94a
Reg. Dist. No.

1. PLACE OF DEATH:

County

Prince George

City or town

Branchville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

33 years

Hospital, Institution, or street address where death occurred:

52nd Place - Branchville, Md.

How long in hospital or institution?

3. (a) FULL NAME

David Luther Howard, Jr.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

Sept 8-1889

8. AGE:

Years 58

Months 9

Days

If less than one day hrs. min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Unemployed

11. Industry or business

David Luther Howard, Jr.

MOTHER FATHER

12. Name

David Luther Howard, Jr.

13. Birthplace

Washington, D.C.

14. Maiden name

Josephine Prather

15. Birthplace

Baltimore, Md.

16. Informant

Miriam H. Wriggand

Address

3711-Hamer Place, 4. Wash. D.C.

17. Burial

Date thereof July 8, 1948

(Burial, cremation, or removal, Which?)

Cemetery or crematory

St. Lincoln

Location

Colmar Manor Md

18. Funeral director

J. Sacks Sons

Address

Hyattsville Md

19. (Date rec'd by registrar)

July 9, 1948. Amanda Towney

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Prince George

City or town

Branchville

Street No.

52nd Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 4th or 5th, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. fo. 19.

and that I last saw h alive on

19.

Immediate cause of death

Coronary Occlusion

Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Mahoney, D.P.M. Esq.
Chesapeake Hyattsville, Md. Date signed 7-5-48

RECEIVED
JUL 10 1948
BUREAU U. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07492

136

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 mos., 25 days

Hospital, institution, or street address where death occurred:

Glen Dale Sanatorium

How long in hospital or institution?..... 2 mos., 25 days

3. (a) FULL NAME

MARY FRANCES

HILL

3. (b) Social Security Number

4. Sex

Female

5. Color or race

negro

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Dennis Hill

7. Birth date of deceased (mo., day, yr.)

June 9, 1914

6.(c) If alive, give age..... 50 years

8. AGE:

Years 34

Months 34

Days 1

If less than one day

Days 7

hrs.

min.

Montgomery County, Maryland

9. Birthplace.....

(Town, county, and state)

10. Usual occupation

Government Cafeteria Worker

11. Industry or business

-

12. Name

Charles Booze

13. Birthplace

Montgomery County, Maryland

14. Maiden name

Isabelle Diggs

15. Birthplace

Montgomery County, Maryland

16. Informant

Deceased

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof..... July 21, 1948

(month) (day) (year)

Cemetery or crematory

Mt. Zion Cemetery

Location

Montgomery County, Md

18. Funeral director

Ray W Barber

Address

Laytonsville Md

July 18, 1948 Rowland S. Phillips

(Date read by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

JULY 16, 1948 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

APR. 20, 1948 to JULY 16, 1948

and that I last saw her alive on JULY 16, 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

5 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

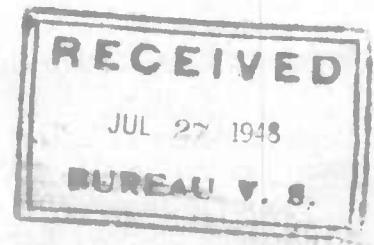
Injured at work?

23. SIGNATURE

Daniel Leo Pinicane M.D.

M. D. or other

Address: Glen Dale Md., Date signed: July 16, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07493

CERTIFICATE OF DEATH

136
Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 days.

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 2 days.

3. (a) FULL NAME

HURT, MYRTLE D.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife..... John Hurt

7. Birth date of deceased (mo. day, yr.) February 23, 1905

8. AGE: Year Months Days If less than one day
43 4 9 hrs. min.

9. Birthplace..... Cottenham, Louisiana

(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name..... Hillary Armand

13. Birthplace..... ? Louisiana

14. Maiden name..... Rozena Gauthier

15. Birthplace..... ? Louisiana

16. Informant..... Deceased

Address

17. removal Date thereof..... July 3, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location..... Washington D.C.

18. Funeral director..... S. H. Hines Co.

Address..... 2901 - 14th St., N.W.

19. 7-3 1948 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1115 Oak Street, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 2 1948 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/30 1948 to 7/2 1948

and that I last saw her alive on 7/2 1948

Immediate cause of death

pulmonary tuberculosis

17 yrs. DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

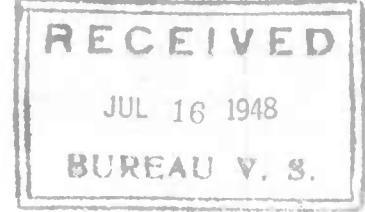
Means of injury

Injured at work?

23. SIGNATURE

Daniel P. Principe M.D. M. D. or other

Address..... Glenn Dale, Md. Date signed..... 7/2/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07494

CERTIFICATE OF DEATH

231

Reg. Dist. No.

1. PLACE OF DEATH:

County, Prince Georges

City or town, Cheverly, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 hours 15 minutes

Hospital, Institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 23 hours 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State, Maryland County, Prince Georges

City or town, Rt. 1 E. Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. Browning Road

(If rural, give LOCATION)

None

3. (a) FULL NAME

Ruth

Irene Ingerson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Married

6.(b) Name of husband or wife

Wm. J. Ingerson

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1897

8. AGE:

Years
50Months
10Days
1

If less than one day

hrs. min.

9. Birthplace, Laurel, Prince George's Md.
(Town, county, and state)

10. Usual occupation, Housewife

11. Industry or business

12. Name, Artemus S. Martin

13. Birthplace, Maryland

14. Maiden name, Cora Bell Phelps

15. Birthplace, Maryland

16. Informant, Gordon W. Martin

Address, 10306 Ridgemoor Dr. Silver Springs, Md.

17. Burial, Date thereof, July 16, 1948
(Burial, cremation, or removal, Which?)

(month, (day) (year))

Cemetery or crematory, WASHINGTON, NAT'L CEMETERY

Location, Suitland, MARYLAND

18. Funeral director, A. H. Chambers Co.

Address, 5801 Cleveland Ave., Riverdale Md.

19. 7/9/48 1948
(Date rec'd by registrar)Amanda Murray
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State, Maryland County, Prince Georges

City or town, Rt. 1 E. Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. Browning Road

(If rural, give LOCATION)

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH, July 8, 1948 19 48 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 July 1948 to 8 July 1948

and that I last saw her alive on 7 July 1948

Immediate cause of death, acute congestive

heart failure

DURATION

24 hrs.

Due to, pneumonia, atypical undetermined

probably 4-5 days.

Due to,

Other conditions, Diabetes mellitus unknown

Unknown

(Include pregnancy within 3 months of death)

Major findings or operations, None

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address, 2200 R 9 Ave. NE Wash. D.C. Date signed, July 1948

RECEIVED
JUL 12 1948
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07495

CERTIFICATE OF DEATH

47d
245

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M W married

6.(b) Name of husband or wife

Norma Jackson

7. Birth date of deceased (mo. day, yr.)

Mar - 8 - 1893

8. AGE: Years Months Days If less than one day

55 5 13 hrs. min.

9. Birthplace

Mark C. P. Cor

(Town, county, and state)

Brick Mason

10. Usual occupation

Robert E. Jackson

S. Cor

11. Industry or business

Mary Adams

S. Cor

12. Name

Norma H. Jackson

S. Cor

13. Birthplace

Mark C. P. Cor

Address

5273-42nd Pl. Hyattsville

Burial

Date thereof July 23 1948

(month) (day) (year)

Cemetery or crematory

Gard Lincoln Cemetery

Location

Prince George's County, Md.

18. Funeral director

W.W.C. Chambers

Address

Bimdale - Md.

19. Date rec'd by Registrar

July 21 1948 Mrs. Jas. S. Lewis

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

and County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

5273-42nd Pl

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21 1948 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10 1948 to July 21 1948

and that I last saw him alive on July 20 1948

Immediate cause of death

Carcinoma of Liver

DURATION

Gave 3rd metastasis

To Liver - Left

Due to 8 cellulitis - Sept fever.

Sept fever.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

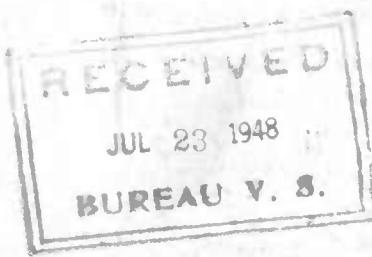
Means of Injury

Injured at work?

23. SIGNATURE

O'Dell, Lee M. D. or other

H. O'Keeffe, Esq. Date signed July 21 1948





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07496

CERTIFICATE OF DEATH

182
Reg. Dist. No. 234

1. PLACE OF DEATH:

County

Clinton, Georgia

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

High Road

How long in hospital or institution?

3. (a) FULL NAME

Violet Savannah Johnson

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Colored

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

Oct 8, 1946

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER

FATHER

Walter Johnson

Maryland

May Lawrence

Washington D.C.

16. Informant

May Johnson

Address Clinton, Ga.

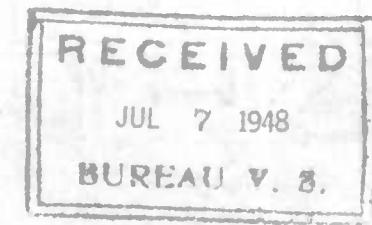
17. Burial

Burial

Date thereof July 6, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07497

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122a

231

CERTIFICATE OF DEATH

Reg. Dist. No.

EVIDENCE FOR CHANGE OF
AGE & BIRTH DATE IS ON:
FILM # 6449 - 3-8-49

1. PLACE OF DEATH:

Prince George's
County

City or town. Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hours

Hospital, institution, or street address where death occurred: Prince George's General

How long in hospital or Institution? 12 hours

3. (a) FULL NAME

Jones, Mr. Charles

4. Sex

m

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

Jan 19, 1870 1871

8. AGE:

Years	Months	Days	If less than one day
78 77	6	22	hrs. min.

9. Birthplace

New York
(town, county, and state)

10. Usual occupation

11. Industry or business

Charlton P Jones

12. Name

Charlton P Jones

13. Birthplace

Wales

14. Maiden name

Mary E. Conkling

15. Birthplace

New York

16. Informant

Hospital Records

Address

Burial

(Burial, cremation, or removal Which?)

At Lincoln

Cemetery or crematory

Colmar Manor Md

Location

F Gascha sons

18. Funeral director

Hyattsville Md

Address

August 3, 1948

(Date signed by registrar)

Amanda Deeney

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Prince Georges

City or town

Landover

Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

White house

Rd

No.

High St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

30 July 1948 at 8:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 29, 1948, to July 30, 1948

and that I last saw him alive on July 30, 1948

Immediate cause of death

Pertonitis

Due to

Rupture of sigmoid Colon

Due to

Fecal Impaction

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Perforation of sigmoid

Colon, Perforation of sigmoid

152

RECEIVED

AUG 5 1948

BUREAU F. B. I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. R. L. Richardson
M.D.

93d

Reg. Dist. No. 232

1. PLACE OF DEATH:

County

George

City or town

Mitchellville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4-6 Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female colored Married

6. (b) Name of husband or wife

Charles Jones

7. Birth date of deceased (mo., day, yr.)

6. (c) Native, give age years

Mar. 15 1884

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Queen Anne [part of] District

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

MOTHER FATHER

Daniel Montgomery

13. Birthplace

Princ George Co Md

14. Maiden name

Catherine Johnson

15. Birthplace

Md.

16. Informant

Charles Jones

Address Mitchellville, P.B. Co. Md

Burial

Date thereof July 17 1948

(Burial, cremation, or removal; which?)

Cemetery or crematory

Location Mitchellville, Md.

Funeral director

Amelia A. Johnson

Address Annapolis

July 17, 1948

Plumb & Son

Registrar

Signature

Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 15 1948

I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 1948 to July 15 1948

and that I last saw her alive on July 15, 1948

Immediate cause of death

Chronic Myocarditis

Due to

arterio - sclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

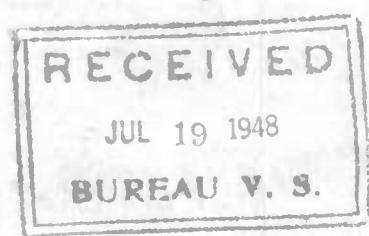
Means of injury

Injured at work?

23. SIGNATURE

Dr. R. L. Richardson M.D. or other

Address 10-878987 7/16/48 Date signed



PLEASE WRITE PLAINLY, WITH
TRADING INK. Supply every item of information carefully.
Physicians: please write the causes of death clearly and legibly.
is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07495

131b
Reg. Dia. No. 242

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County 7832

Prince George County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Annie C

Kidwell

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

George W Kidwell

7. Birth date of deceased (mo., day, yr.)

Oct 10, 1857

6. (c) If alive, give age years

8. AGE:

Years 90

Months 9

Days 11

If less than one day

....hrs.min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

William McKinney

12. Name

Wm

13. Birthplace

Va

14. Maiden name

Mary E. Chisholm

15. Birthplace

Va

16. Informant

Mrs Jerry Coyle

Address

7832

Marlboro Pike

17. Burial

Date thereof July 24, 1948

(Burial, cremation, or removal. Which)

(month) (day) (year)

Cemetery or crematory

Rock Creek

Location

Washington D.C.

18. Funeral director

Address 7901-14 St NW Wash DC

Address

Date rec'd by registrar

19. Date rec'd by registrar

1948

Eduard F. Geller

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(or newborn infants give residence of mother)

State

Maryland County

City or town

Forestville

Street No.

7832 Marlboro Pk.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21 1948 at 7:20 PM

I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1, 1945 to July 21, 1948
and that I last saw her alive on July 21, 1948

Immediate cause of death Dehydration & Pulmonary

Obstruction
Dysentery
Diarrhea

Due to old age 90 yrs

Due to cerebral hemorrhage

Other conditions cl. subdural hematoma

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

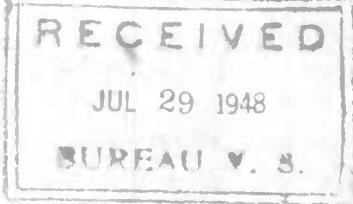
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 2748-29-409 Date signed July 24, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07500
170C

CERTIFICATE OF DEATH

Reg. Dist. No. 245

MARGIN RESERVED FOR BINDING
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

Prince Georges

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

In transit

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Frances-Louise Kirk

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W.

Married

6. (b) Name of husband or wife

Albert S. Kirk

7. Birth date of deceased (mo., day, yr.)

Mar 17, 1889

6. (c) If alive, give age

59

years

8. AGE:

Years

Months

Days

It less than one day

59

3

19

hrs.

min.

9. Birthplace

Wheeling, W. Va

(Town, county, and state)

10. Usual occupation

Gas Station attendant

11. Industry or business

MOTHER FATHER

Gebart Otter

12. Name

Germany

13. Birthplace

Baltimore

14. Maiden name

Germany

15. Birthplace

Germany

16. Informant

Howard Kirk

Address

Munster, Md.

17. Burial

Burial July 9, 1948

(Burial, cremation, or removal. Which?)

Date therapy

(month) (day) (year)

Cemetery or crematory

Mt. Lincoln

Location

Colmar Manor Md

18. Funeral director

J. G. Gacke Son

Address

Hyattsville Md

19. July 9th

1948

Mrs. J. G. Gacke

Health Socio Registrars

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

Maryland

County

Pr. George

City or town

Md. Inlet Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Wash-Balt. Boulevard.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 6

1948 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

to

19...

and that I last saw h... alive on

Immediate cause of death

Hemorrhage & shock

DURATION

Due to

Multiple lacerations of face sudden

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of July 6, 1948

Where did injury occur?

Oak Crest Pr. Sub - Md.

(City or town) (Country) (State)

Injured at home, farm, industry, public place (where?)

Public Highway

Means of injury

Auto accident

Injured at work? No

23. SIGNATURE

John J. Maloney, M.D., Esq.
M. D. or other

Address

Cheverly - Md.

Date signed 7-6-48

RECEIVED
JUL 10 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07501
138

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 yr., 3 mos., 7 days.

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 1 yr., 3 mos., 7 days.

3. (a) FULL NAME

VIRGINIA KLEINBERG

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Single

6.(b) Name of husband or wife.....

- - -

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

July 21, 1925

8. AGE:

Years
23Months
23Days
0If less than one day
10

hrs.

min.

9. Birthplace.....

Iron Mt., Michigan

(Town, county, and state)

10. Usual occupation.....

Personnel Clerk

11. Industry or business.....

- - -

MOTHER FATHER

12. Name..... Fred H. Kleinberg

13. Birthplace..... ? Lithuania

14. Maiden name.....

Lydia ?

15. Birthplace.....

? Pennsylvania

16. Informant.....

Deceased

Address

17. Burial..... Aug. 1, 1948
(Burial, cremation, or removal. Which?) Date thereof. (month) (day) (year)

Cemetery or crematory..... cemetery

Location.....

Neenah, Wisconsin

18. Funeral director.....

W.W. Chambers Co.

Address.....

3072-M-ST N.Y.

19. 7-31-48 Rowland S. Phillips
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C.

County.....

4872 McArthur Blvd., Washington

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

4872 McArthur Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

- - -

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

JULY 31 1948 at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

APR. 23 1947 to JULY 31 1948

and that I last saw her alive on

JULY 31 1948

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

1 yr. 8 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

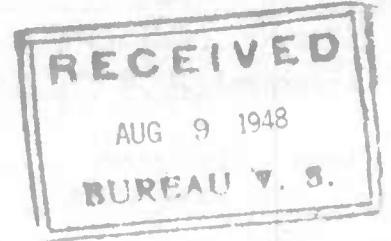
23. SIGNATURE

Daniel Leo Finegan M.D.

M. D. or other

Address..... Glen Dale, Md. Date signed. 7-31-48

MARGIN RESERVED FOR BINDING
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
 is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

CERTIFICATE OF DEATH

Reg. Dist. No. 117512

1. PLACE OF DEATH:
 County Prince George
 City or town Upper Marlboro
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Largo Road

How long in hospital or institution?

3. (a) FULL NAME

Ambrose Howard Lewis

4. Sex Male 5. Color of face White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) June 24, 1947 8. (c) If alive, give age years

8. AGE: Years 1 Months 1 Days 3 If less than one day
 hrs. min.

9. Birthplace Upper Marlboro, Md.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER
 12. Name Ambrose Lewis
 13. Birthplace Clinton, Md.

14. Maiden name Bessie Sweeney
 15. Birthplace Upper Marlboro, Md.

16. Informant Ambrose Lewis - father
 Address Upper Marlboro, Md.

17. Burial Burial Date thereof July 29, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Trinity Episcopal Church Cemetery

Location Upper Marlboro, Md.

18. Funeral director Ridgely Bros.
 Address Upper Marlboro, Maryland.

19. (Date rec'd by registrar) July 29, 1948 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md. County Prince George
 City or town Upper Marlboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Largo Road
 (If rural, give LOCATION) no

2.(a) If veteran, name war no

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH June July 27 1948 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw him alive on 19.

Immediate cause of death

Sophyphoxia

DURATION

Due to Suffocation

Due to Fell into a stop barrel

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

...Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-27-48

Where did injury occur Upper Marlboro, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fell in stop barrel At work? No

Deputy medical examiner

23. SIGNATURE Ambrose J. Lewis M. D. or other Surgeon

Date signed July 27, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07503

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County

Prince George's County

City or town

Dead Brook

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

— week

Hospital, institution, or street address where death occurred:

—

How long in hospital or institution?

—

3. (a) FULL NAME

ETHEL LILLIAN LOWRY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Hwife

Married

Calvert Lowry

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec 21, 1890

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

..... hrs. min.

9. Birthplace

Seabrook Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Benjamin F. Binnix

12. Name

Sunberry Pa.

13. Birthplace

Emma Jane Kagle

14. Maiden name

Seabrook, Md.

15. Birthplace

Calvert Lowry

16. Informant

426 First St. S.E.

Address

Burial

Date thereof July 13, 1948

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Fort Lincoln Cemetery

Location Prince George County, Md.

18. Funeral director

John E. Chamberlin

Address

517 11th Street S.E.

19. Date rec'd by registrar

1948

Amanda Denny

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D.C.

County

City or town

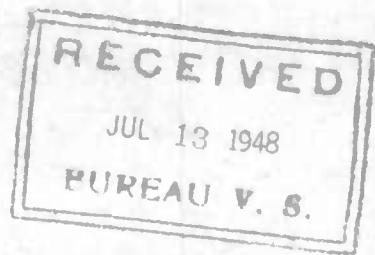
Washington

County

Street No.

426 - 1st St.

Street



EVIDENCE FOR CHANGE
OF AGE SHOWN ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07504

FAM No. G 116 AUG 5 - 1948

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Leland Memorial Hosp

How long in hospital or institution?

3. (a) FULL NAME

Louis Sloughas Mayhugh Jr

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Oct 24, 1932

8. AGE:

Years

Month

Days

If less than one day

15 16

8

23

hrs.

min.

9. Birthplace

(Town, county, and state)

washington D.C.

10. Usual occupation

Unemployed

11. Industry or business

MOTHER FATHER

12. Name

Louis Sl Mayhugh

13. Birthplace

Iva

14. Maiden name

Evelyn Lockett

15. Birthplace

md

16. Informant

Charles E. Beach

Address

6528 Inglewood Parkway Rosedale Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 19 - 1948

(month)

(day)

(year)

Cemetery

Location

Funeral director

Address

18. Funeral director

Address

19. Death certificate

(Date rec'd by registrar)

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

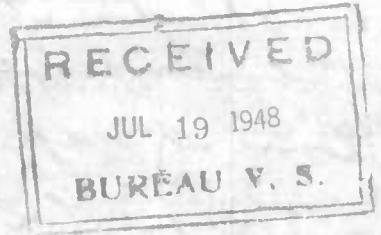
1948

1948

1948

1948

<p



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

466
075115

CERTIFICATE OF DEATH

Reg. Dist. No. 29

MARGIN RESERVED FOR BINDING
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In-incorrect age
 is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County Prince George

City or town of Laurel
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Warren Hospital

How long in hospital or Institution? 2 weeks

3. (a) FULL NAME

Nellie Mays

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

George F. Mays

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

March 24, 1879

8. AGE:

Years 69

Months 3

Days 13

If less than one day

hrs.

min.

9. Birthplace

Port Republic, Virginia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

MOTHER FATHER

12. Name Walter Palmer

13. Birthplace

Tenn.

14. Maiden name

Catherine

15. Birthplace

Virginia

16. Informant

Mrs Catherine Fairall

Address

909 Montgomery Ave

Burial

Date hereof July 9, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Laurel Hill Cemetery

Location

Laurel, Maryland

18. Funeral director

De Witt Donaldson

Address

Laurel, Maryland

19. Date rec'd by registrar

July 9, 1948 M. Brashears

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 409 Montgomery Road
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 7 1948 at 3:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to July 7 1948

and that I last saw her alive on July 6 1948

Immediate cause of death

Carcinoma of stomach DURATION 6 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Inoperable carcinoma of stomach Date of op. June 14, 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

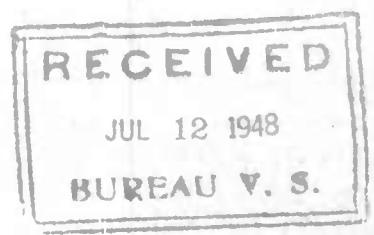
Means of injury

Injured at work?

23. SIGNATURE

Stephens, Md. M. D. or other

Address Laurel, Maryland Date signed 7/8/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07506

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

PRINCE GEORGES

County or town CHEVERLY

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 DAYS, 12 HRS. 50 min.

Hospital, institution, or street address where death occurred:

PRINCE GEORGES GENERAL HOSPITAL

How long in hospital or institution? 3 Days, 12 hrs. 50 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Mt. Ranier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3304 Otis Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mr. George Mezzanotte

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1873

8. AGE: Years Months Days If less than one day
71 8 23 hrs. min.9. Birthplace Austria
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER
12. Name Unknown
13. Birthplace14. Maiden name Unknown
15. Birthplace

16. Informant James Mezzanotte

Address 3304 - Otis St. Mt. Ranier

17. Burial Date thereof July 7, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Colmar Manor Md.

18. Funeral director Wm. J. Waller

Address 3200 - R. I. Ave. Mt. Ranier

19. Date rec'd by registrar July 6, 1948
Address Prandila Deering
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1948, at 8:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1, 1948, to July 5, 1948,
and that I last saw him alive on July 4, 1948.

Immediate cause of death Acute Pulmonary

Edema

Due to Chronic myocarditis

Due to

Other conditions Generalized

Arthritis, etc.

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis B. Bachrach M.D.

M. D. or other

Address 915-19th St. N.W. Date signed July 5, 1948

RECEIVED
JUL 8 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932
175117
246

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County PRINCE GEORGES

City or town HYATTSVILLE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

CHARLES SAMUEL MITCHELL SR.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE

WHITE

WIDOWED

6. (b) Name of husband or wife Lillie

7. Birth date of deceased (mo., day, yr.)

JULY 1 1862

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

MADISON CO. VIRGINIA

(Town, County, and state)

10. Usual occupation

CARPENTER (RETIRRED)

11. Industry or business

ALBERT MITCHELL

12. Name

VIRGINIA

13. Birthplace

NOT KNOWN

14. Maiden name

VIRGINIA

15. Birthplace

MRS EDDIE GROVES (DTR.)

16. Informant

4006 OLIVER ST. HYATTSVILLE

Address

Burial, cremation, or removal. Which?

17. Cemetery or crematory

Date thereof. JULY 10, 1948
(month) (day) (year)

Location

Cedar Hill
Suitland Pk Geo. Co., Md.

18. Funeral director

Address 5801 Cleveland Ave

19. (Date rec'd by registrar)

July 9 1948 James Jersey

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County

PRINCE GEORGES

City or town HYATTSVILLE

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4006 OLIVER ST.

(If rural, give LOCATION)
NONE

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 8

1948

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2

1944

to July 8 1948

M

and that I last saw him alive on

July 4

1944

Immediate cause of death

Inocardiovascular deficiency

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. D. - C. D.

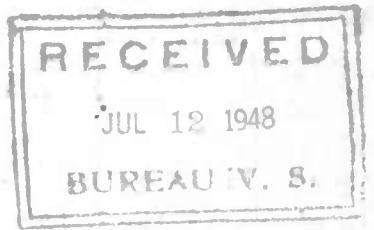
M. D. or other

Address

Hyattsville, Md.

Date signed

08/08



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				
County..... Prince Georges				
City or town..... Glenn Dale, Maryland				
(If outside city or town limits, write RURAL and give nearest town)				
How long in above place of death?..... 4 mos., 5 days				
Hospital, institution, or street address where death occurred:..... Glenn Dale Sanatorium				
How long in hospital or institution?..... 4 mos., 5 days				
3. (a) FULL NAME				
CLAYRETHA MONTGOMERY				
4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
Female	Negro	Married		
6.(b) Name of husband or wife..... Howard Montgomery				
6.(c) If alive, give age..... 21 years				
7. Birth date of deceased (mo. day, yr.)..... November 18, 1927				
8. AGE:	Years	Months	Days	If less than one day
20	20	7	29	hrs. min.
9. Birthplace..... Washington, D. C.				
(Town, county, and state)				
10. Usual occupation..... Housewife				
11. Industry or business.....				
12. Name..... Walter Johnson				
13. Birthplace..... Washington, D. C.				
14. Maiden name..... Alice Turner				
15. Birthplace..... Washington, D. C.				
16. Informant..... Deceased				
Address				
17. Burial, cremation, or removal. Which?..... Buried to bushels				
Date thereof..... July 17, 1948 (month) (day) (year)				
Cemetery or crematory.....				
Location.....				
18. Funeral director..... John T Rhines & Co - Wm Spangler				
Address..... 901-3rd St S.W.				
19. (Date rec'd by registrar)..... July 17, 1948 (month) (day) (year)				

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

117508

243

Reg. Dist. No.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 253 V. St., N. W., Apt. #21

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

578-30-2930

MEDICAL CERTIFICATION

20. DATE OF DEATH..... JULY 17, 1948, at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 11, 1948, to JULY 17, 1948,

and that I last saw her..... alive on JULY 17, 1948

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

6 mo

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

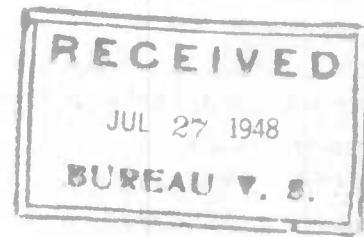
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Finesman M.D.

M. D. or other

Address..... Glen Dale Md. Date signed..... 7-17-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07509
160c

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George

City or town Rockville Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days 9 hrs. 5 min.

Hospital, institution, or street address where death occurred:

Island Memorial Hosp. Rockville Md

How long in hospital or institution? 2 days 9 hrs. 5 min.

3. (a) FULL NAME

Baby Girl Ogle -

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

white

infant

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age. 2 days

July 5, 1948

8. AGE: Years Months Days It less than one day

2

9

hrs.

5

min.

9. Birthplace

Island Memorial Hosp. Rockville
(Town, county, and state)

10. Usual occupation

infant

11. Industry or business

MOTHER FATHER

12. Name Edward Larson Ogle

13. Birthplace De Queen, Arkansas

14. Maiden name Mrs. Edward Florence Shaffer Ogle

15. Birthplace Greenville, South Carolina

16. Informant Mrs. Edna Florence Ogle

Address 11 Nicholson St. N.W. Wash. D.C.

Burial

(Burial, cremation, or removal. Which?)

Date thereof July 9, 1948

Cemetery or crematory Evergreen

Location Bladensburg Md

18. Funeral director E. Sachs son

Address Hyattsville Md

19. Date rec'd by registrar July 9, 1948

(Date rec'd by registrar) M.S. (See below)
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C.

County District of Columbia

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 Nicholson St. N.W. Wash. D.C.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 8, 1948 at 5:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 5, 1948, to July 8, 1948
and that I last saw her alive on July 8, 1948

Immediate cause of death

Prematurity - 6 1/2 mos pregnancy

Due to

Abruption placenta

DURATION

2 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

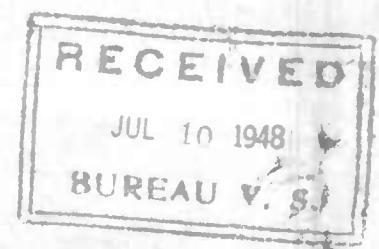
Injured at work?

23. SIGNATURE

M. D. or other

Address

Signature signed 7-8-48



131a

07510

247

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Prince Georges

City or town

Rosaryville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years 60 days

Hospital, Institution, or street address, where death occurred:

Lower House

How long in hospital or institution?

3. (a) FULL NAME

Eleanor Medill Patterson

4. Sex

Female White 5. Color or race Wedowed.

6.(b) Name of husband or wife

Eleanor Schlesinger

7. Birth date of deceased (mo. day. yr.)

November 7, 1884

8. AGE:

Years Months Days If less than one day hrs. min.

9. Birthplace

Chicago, Ill. (Town, county, and state)

10. Usual occupation

Newspaper Publisher

11. Industry or business

Newspaper

FATHER

12. Name

Patent Patterson

13. Birthplace

Illinois

14. Maiden name

Elinor Medill

15. Birthplace

Illinois

16. Informant

Frank Waldrop

Address

4900 Loughboro Rd NW, Wash. D.C.

17. CREMATION

(Burial, cremation, or removal. Which?)

Date thereof: July 27, 1948

(month) (day) (year)

Cemetery or crematory

CEDAR HILL

Location

SUITLAND MD.

18. Funeral director

Jos. Jaworski Sons

Address

1254 Pennsylvania Ave. N.W. Wash. D.C.

19. July 24, 1948
(Date reg'd by registrar)

Carrie F. Campbell
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED: WASHINGTON DC
(For newborn infants give residence of mother)

State

Washington County Prince Georges

City or town

Washington D.C. Washington DC

Street No.

1201 15th Street N.W. Dupont

(If rural, give LOCATION)

Circle, N.W. ✓

2.(a) Is veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 24, 1948, at 2:58 P.M.

and that I last saw her alive on 19

Immediate cause of death

Acute Congestive heart failure

Due to Cardioscircular cerebral disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

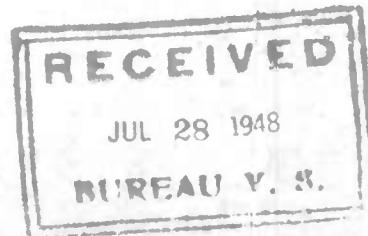
23. SIGNATURE

J. J. Jaworski M. D. or other

Address: 1254 Pennsylvania Ave. N.W. Wash. D.C. Date signed: July 24, 1948

mem - res copy made 8/3/48
etc

Manuscript
Ceramic
8/27/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07511

245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Prince George's
Riverdale Md.

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

72 days

Hospital, institution, or street address where death occurred:

Augusta Belair Memorial Hosp.

How long in hospital or institution?.....

72 days

3. (a) FULL NAME

Mrs Antoinette Francis Peterson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Fe White Single

6. (b) Name of husband or wife.....

single

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

abt 1867

8. AGE:

Years

Months

Days

If less than one day

..... hrs. min.

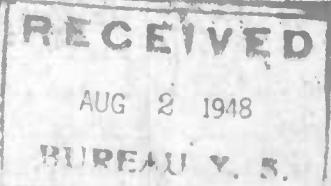
9. Birthplace.....

New York -

(Town, county, and state)

10. Usual occupation.....

Post Office Employee



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46d

07512
243

Reg. Dist. No.

1. PLACE OF DEATH:
County..... Prince Georges

City or town..... Glenn Dale - (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 66 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution?..... 66 days

3. (a) FULL NAME

POLANSKY, Essie

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	married

6. (b) Name of husband or wife..... Samuel Polansky

7. Birth date of deceased (mo., day, yr.)..... November 10, 1901

8. AGE:	Years	Months	Days	If less than one day
	46	8	13	hrs. min.

9. Birthplace..... Russia
(Town, county, and state)

10. Usual occupation..... housewife

11. Industry or business..... -

MOTHER FATHER
12. Name..... Benjamin Gordon

13. Birthplace..... Russia

14. Maiden name..... Anna ? (unable to recall)

15. Birthplace..... Russia

16. Informant..... deceased

Address.....

17. Burial (Burial, cremation, or removal. Which?)
Date thereof..... July 25, 1948
(month) (day) (year)

Cemetery or crematory..... Kasher Israel Cemetery

Location..... Capital Heights, Prince Georges, Md.

18. Funeral director..... S. Polansky & Son

Address..... 3501 - 14th St. NW. Washington, D.C.

19. (Date rec'd by registrar)..... July 24, 1948

Registrar.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D.C. County.....

City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1010-17th St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 23, 1948, at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 18, 1948, to July 23, 1948, fe. July 23, 1948,
end that I last saw her alive on July 23, 1948.

Immediate cause of death.....

Pulmonary Tuberculosis

Due to.....

Due to..... Concussion of Lecture

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

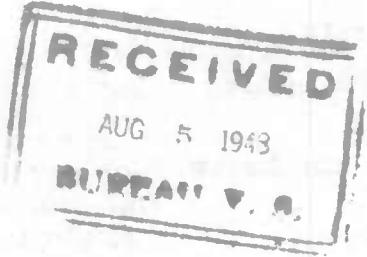
Means of injury.....

Injured at work?

23. SIGNATURE..... Daniel Leo Finegan, M.D.

M. D. or other.....

Address..... Glenn Dale, Md., Date signed..... July 23, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07513

111C

231

Reg. Dist. No.

1. PLACE OF DEATH:

County PRINCE GEORGE'SCity or town CHEVY CHASE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 99 days 4 hrs

Hospital, Institution, or street address where death occurred:

PRINCE GEORGE'S GENERAL HOSPHow long in hospital or institution? 99 days 4 hrs

3. (a) FULL NAME

MARION Potts

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Fem.

W.

widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

March 25, 1878

8. AGE:

Years

Months

Days

If less than one day

70

3

21

hrs.

min.

9. Birthplace

(Town, county, and state) South Carolina

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial
(Burial, cremation, or removal. Which?) BurialDate thereof July 20, 1948
(month day year)Cemetery or crematory Cedar HillLocation MaywoodFuneral director J.W. Lee Sons CoAddress 300-4th ST N E Washington DC19. 7/17/48 (Date rec'd by registrar)19. Amanda Doury (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Berwyn (If outside city or town limits, write RURAL and give nearest town)Street No. 4824 Osage St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

16 July

19

48 at 11³⁰/P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 19

19 48, to

7 16

19 48

and that I last saw him alive on

Immediate cause of death Pulmonary edema DURATIONDue to Fragile reed of left
jejunum wall.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide old accident Date of about 1944Where did injury occur? Washington D.C. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Ridge Dr. Hardley

Means of injury

Injured at work? No

23. SIGNATURE

Henry L. Daffer M.D.

M.D. or other

Address 1918 K St. N.W. Date signed 7/21/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1640

07514

230

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Prince Georges
City or town Berwyn, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred:
5014 Iroquois Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Pr. Georges
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5014 Iroquois Street
(If rural, give LOCATION)
2.(a) if veteran, name war World War I

3. (a) FULL NAME

Raymond Anderson Prettyman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) November 22, 1887

8. AGE; Years	Months	Days	If less than one day
60	7	18	hrs. min.

9. Birthplace Salisbury, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name John A. Prettyman

13. Birthplace Salisbury, Md.

14. Maiden name Ella Jones

15. Birthplace Salisbury, Md.

16. Informant John E. Prettyman

Address 720- 17th Street, N.W. Wash., D.C.

17. Burial Date thereof July 14, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va

18. Funeral director F. Glass & Sons

Address Hyattsville 4yd.

19. July 13th, 1948 John W. Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1948 a.m. ? p.m. ?

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on 19. to 19.

Immediate cause of death

Gunshot wound through head.
Intercranial hemorrhage; shock.

Due to

Due to

Other conditions Cardio-vascular renal disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 7-10-48

Where did injury occur? Berwyn, Pr. Geo. Maryland
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Self inflicted Injured at work?

23. SIGNATURE John J. Maloney Dep. Med. Examiner
M. D. or other

Address Chevy Chase, Md. Date signed 7-17-48

M
The correct age

RECEIVED

JUL 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07515

245

CERTIFICATE OF DEATH

93d
Reg. Dist. No.

1. PLACE OF DEATH

County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

2705 - Green's Chapel Road

How long in hospital or institution?

3. (a) FULL NAME

Isabel Arthur Ray.

4. Sex

5. Color or race

6. (a) Single, married, widowed or divorced

Female

White

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

July 7, 1883

8. AGE:

Years Months Days

If less than one day

65

23

9. Birthplace

Wash. D. C.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Mr. Whifield Arthur

12. Name

13. Birthplace

D. C.

14. Maiden name

Unknown

15. Birthplace

16. Informant

Gertude Bumper (wife)

Address

Mt. Rainier, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

7-31-48

(month day year)

Cemetery or crematory

Rock Creek Cemetery

Location

Wash. D. C.

18. Funeral director

W. F. Hartman

Address

5732 Ga Line

19. Date read by registrar

July 29 1948 James Berry

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hyattsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2705 - Green's Chapel Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 28 1948 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on

Immediate cause of death

Idiopathic Heart Disease

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John W. Mahoney, Examiner

M. D. or other

Address Chelverton Hyattsville Date signed 7-29-48

RECEIVED
JUL 31 1948
BUREAU F. B. I.

M PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07516

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

Prince Georges

County

Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

2 yrs., 3 mos., 3 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 2 yrs., 3 mos., 3 days

3. (a) FULL NAME

UHLAND B. RICHARDSON

4. Sex

5. Color or race

Male

Negro

6. (a) Single, married, widowed, or divorced

Separated

6. (b) Name of husband or wife

Hattie Mae Mokely

7. Birth date of deceased (mo., day, yr.)

October 2, 1912

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

35

35

9

20

hrs.

min.

9. Birthplace

Saluga, South Carolina

(Town, county, and state)

Laborer

10. Usual occupation

11. Industry or business

12. Name

Wiley Richardson

13. Birthplace

Saluga, South Carolina

14. Maiden name

Minnie Hubbard

15. Birthplace

Saluga, South Carolina

16. Informant

Deceased

Address

Burial

Date thereof July 25 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Community Plot

Location

Saluga, South Carolina

18. Funeral director

Perner Memorial Funeral Service

Address

24 H St. NW, - DC.

19. Date rec'd by registrar

July 25 1948 Roseland & Phillips

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D. C.

County

City or town

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

831 Second St. S. W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

246-07-1069

MEDICAL CERTIFICATION

20. DATE OF DEATH

JULY 22 1948 at 12²⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

APR. 18 1946 to JULY 22 1948

and that I last saw h. i. m. alive on

JULY 22 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

2 yrs 4 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

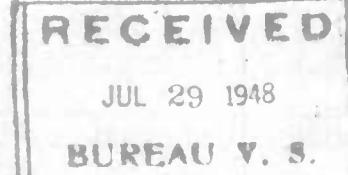
23. SIGNATURE

Daniel Leo Pinecar MD

M. D. or other

Address

Glen Dale, Md. Date signed 7-22-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07517

CERTIFICATE OF DEATH

93d

245

Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours and 10 min.

Hospital, Institution, or street address where death occurred:

Eugene Hospital Memorial Hospital

How long in hospital or institution? 2 hours and 10 min.

3. (a) FULL NAME

Miss Pauline Hattie Robey

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Single (Divorced)

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.) Oct. 3rd 1896

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

5 9 3 hrs. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James Robey

13. Birthplace Maryland

14. Maiden name Adeline Robey

15. Birthplace Maryland

16. Informant Mrs. Selma Kelly

Address Beltsville Maryland

17. Burial Burial

(Burial, cremation, or removal. Which?)

Date thereof July 8 1948

Cemetery or crematory Greenlawn

Location Broadacres Md.

18. Funeral director Timothy Hanlon

Address 641-A 19th & Wash D.C.

July 6 1948 James Seavey

(Date rec'd by registrar)

T Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County PRINCE GEORGES

City or town Beltsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

6 July 1948 48 10 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 48 to 6 July 1948

and that I last saw her alive on 6 July 1948

Immediate cause of death

CEREBRAL Thrombosis

DURATION

1 day

Due to HYPERTENSIVE
CARDIO-VASCULAR Disease 5 yrs +

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

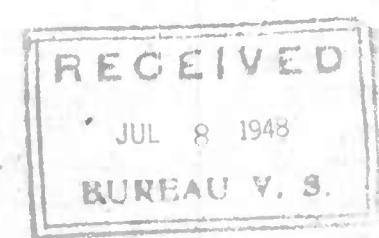
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address Dr. L. Etienne
Baltimore, Md. M. D. mother
Date signed 7-6-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07518

CERTIFICATE OF DEATH

136
Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 8 mos., 23 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 8 mos., 23 days

3. (a) FULL NAME

JULIA L. SALES

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

Edward Sales

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 14, 1910

8. AGE:

Years
38Months
38Days
0If less than one day
2

hrs. min.

9. Birthplace

Caroline County, Virginia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

Robert Satterwhite

Caroline County, Virginia

14. Maiden name

Mary E. Nowell,

15. Birthplace

Caroline County, Virginia

16. Informant

Deceased

Address

17. Removal to Washington D.C. Date thereof. (Burial, cremation, or removal. Which?)
July 16, 1948
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director
J. O. W. Lee Sons Co.
Address 306 - 4th St. N.E.
Washington D.C.19. Address Washington D.C.
Date July 16, 1948
(Date rec'd by registrar) Rowland S. Phillips
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Virginia County.....

City or town..... Richmond
(If outside city or town limits, write RURAL and give nearest town)Street No..... 101 E. Main St.,
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

- - -

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 16,

1948, at 6:26 A.M.

21. I CERTIFY that death occurred on the date above stated; That I attended deceased from

Oct. 22, 1947, to

July 16, 1948

and that I last saw her alive on

July 15, 1948

Immediate cause of death

Pulmonary Tuberculosis 3 yrs. 11 mos.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

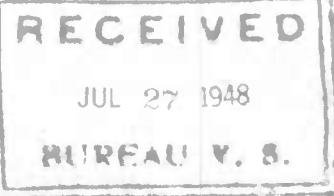
Injured at work?

23. SIGNATURE

M. D. or other

Address

Daniel Leo Pinches M.D.
Glenn Dale, Md. Date signed 7/16/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07519

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges
City or town Larchmont
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Francis Schamontet

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Oliver Pearl Schamontet

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 37 years

Jan 13, 1905

8. AGE: Years

Months

Days

11 less than one day

43 6 22

hrs.

min.

9. Birthplace

Washington D.C.
(town, county, and state)

10. Usual occupation

Laboratory M. schamontet

11. Industry or business

Bu. of Standards

12. Name

Francis Schamontet

13. Birthplace

Geneva, Switzerland

14. Maiden name

Phenix,

15. Birthplace

Jacques Switzerland

16. Informant

Oliver Pearl Schamontet

Address

Larchmont, Md. (Wife)

17. Burial

Date thereof July 8, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

(month) (day) (year)

Mt. Olivet

Location

Washington D.C.

18. Funeral director

E. Schaefer Son

Address

Hyattsville Md

19. Date rec'd by registrar

1948

Amanda J. Brown

Bennet

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Geor.

City or town Larchmont
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 5

1948 at 6:15p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h alive on

Immediate cause of death

Coronary Occlusion

Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

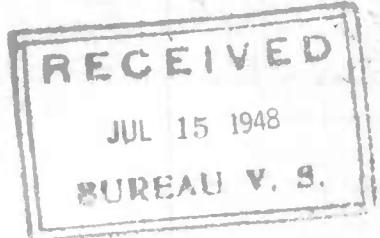
Means of Injury

Injured at work?

23. SIGNATURE John J. Maloney, D.P.M. D.E.A.M.

M.D. or other

Address Cheverly-Hyattsville, Md. Date signed 7-5-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07520

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:

County

City or town.

Bryce George
Bettontown Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

One week

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Benleah Mae Sink

3. (b) Social Security Number

4. SEX

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

married

6. (b) Name of husband or wife

Henley Sink

7. Birth date of deceased (mo., day, yr.)

April 1, 1907

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

pre. min.

9. Birthplace

North Carolina

(town, county, and state)

10. Usual occupation.

Housewife

11. Industry or business

Unknown

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Henley Sink

Address

Sarasota - Florida

17. Transportation

Date thereof July 17, 1948

(Burial, cremation, or removal? Which?)

(month) (day) (year)

Cemetery or crematory

Gastonia

Location

North Carolina

18. Funeral director

T. Gasch's sons

Address

Syattsville Md.

19. July 17, 1948

(Date rec'd by registrar)

John D. Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

North Carolina

County

City or town Gastonia

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 16, 1948 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 11, 1948 to June 16, 1948

and that I last saw her alive on July 3, 1948

Immediate cause of death

Metastatic Colorectal carcinoma of uterus

Due to

Woplman

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Adeno carcinoma of uterus

(Dr. Stephen E. Stebbins, M.D.)

Date of op.

Sept. 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

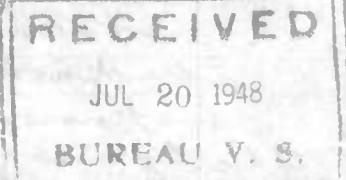
Injured at work?

23. SIGNATURE

J. Stephens, M.D.
Lawer, Md.

M. D. or other

Date signed 7/17/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DISTRICT OF COLUMBIA HEALTH DEPARTMENT, BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH: Dr. George Co.
 (a) Street address Eastern Ave NE
 (b) Name of hospital or institution _____
 (c) Length of stay: In hospital or institution _____
 (d) In District of Columbia _____

3. (a) FULL NAME (Print) HENRY Lee SMITH

3. (b) SOCIAL SECURITY NO. 220-09-9657

3. (c) IF VETERAN, NAME WAR None

4. SEX:	5. COLOR OR RACE	6. (a) SINGLE, MARRIED, WIDOWED, DIVORCED
Male	White	Married

6. (b) NAME OF HUSBAND OR WIFE Nora Flo Smith

7. BIRTH DATE OF DECEASED Oct. 21 1886
 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If LESS than one day hr. min.
61			

9. BIRTHPLACE Red Lion Renn.
 (City, town or county) (State or foreign country)

10. USUAL OCCUPATION Clothier

11. INDUSTRY OR BUSINESS Hilton's Shop

Father { 12. NAME (Print) Frank Smith

13. BIRTHPLACE York Co. Penn.
 (City, town, or county) (State or foreign country)

Mother { 14. MAIDEN NAME (Print) Arvilla Givens

15. BIRTHPLACE York Co. Penn.
 (City, town, or county) (State or foreign country)

16. (a) INFORMANT Nora Flo Smith

(b) ADDRESS 4601 Eastern Ave NE

(c) RELATION OF INFORMANT TO DECEDED Wife

17. (a) PLACE OF BURIAL, CREMATION, OR REMOVAL

Red Lion York Co Penns.

(b) DATE (Month) (Day) (Year)

18. (a) The S. H. Bline Co.
 (Signature of funeral director)

(b) ADDRESS 2901-14th St. N.W.

2. USUAL RESIDENCE OF DECEASED:

(a) State D.C. Md. (b) County Gra.
 (c) City or town Washington
(If outside city or town limits write RURAL)
 (d) Street address 1601 Eastern Ave NE
(If rural give location)
 (e) Citizen of what country?

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1947
 (Month) (Day) (Year)

at _____
 (State exact time of death) 4:00 A.m.

21. I HEREBY CERTIFY that I attended the deceased from

June 14, 1947 to July 7, 1947

That I last saw him alive on July 6, 1947;
 and that death occurred on the date and hour stated above.

Immediate cause of death

Congestive Heart Failure
 Due to Coronary Heart Disease

Due to _____

Other conditions _____

(Include report of pregnancy within 3 months of death)

OPERATION:

Name _____ Date _____

Major findings _____

Autopsy findings _____

DURATION

10 days

3 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, in industrial place, in public place?
 (Specify type of place) _____
 (e) Means of injury _____

23. SIGNATURE Joseph N. Watson M.D.
 Address 1822 Belmont Date signed July 7, 1947

M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

07521

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County.....

Prince Georges

City or town.....

Bowie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Street

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

James G. E. Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Married

6. (b) Name of husband or wife

Teresa Marie Smith

7. Birth date of deceased (mo., day, yr.)

Jan 6, 1904

8. AGE:

Years
44Months
6Days
24If less than one day
hrs. min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business.....

James W. Smith

MOTHER FATHER

12. Name.....

Josephine Windsor

13. Birthplace.....

Maryland

14. Maiden name.....

Josephine Windsor

15. Birthplace.....

Maryland

16. Informant.....

Theresa Marie Windsor

Address.....

Mitchellville Md.

17. Burial.....

Burial

Date thereof.....

Aug 3, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Arlington Cemetery

Location.....

Virginia

18. Funeral director.....

F. Gascha sons

Address.....

Hyattsville Md.

19. Date rec'd by registrar.....

Aug 3rd 1948

(Date received by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

Montgomeryville

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

World War # 2

3. (b) Social Security Number

579-05-0194

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

July 30

1948 at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to

19.....

and that I last saw him alive on

Immediate cause of death.....

Compound comminuted fracture of base of skull

Duration
sudden

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of 7-30-48

Where did injury occur?.....

(City or town) Bowie - Prince George County, Md.

(State)

Injured at home, farm, industry, public place (where?) Public H. Hospital

Means of injury Fall from truck Injured at work?

Signature John J. Maloney, M.D. Examiner

Address 1700 University - Maryland Date signed 7-30-48

Registrar

RECEIVED
AUG 9 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07522

843

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Prince Georges Co.

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 1 days

3. (a) FULL NAME

Ruth Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Single

6. (b) Name of husband or wife..... - - -

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

March 16, 1911

8. AGE:

Years
37Months
37Days
4

If less than one day

hrs. min.

9. Birthplace..... Rappidan, Virginia

(Town, county, and state)

10. Usual occupation..... Practical Nurse

11. Industry or business

- - -

12. Name..... Robert N. Smith

13. Birthplace..... Rappidan, Virginia

14. Maiden name..... Mary A. Yates

15. Birthplace..... Rappidan, Virginia

16. Informant..... Deceased

Address

17. Burial..... Burial
(Burial, cremation, or removal. Which?)Date thereof..... July 22, 1948
(month) (day) (year)

Cemetery or crematory

Location..... Cedar Hill Cemetery

Prince George's County, Md.

18. Funeral director..... James O. Puffin

Address..... 317 Pa Ave S E

19. Date record by registrar..... July 20, 1948 Rowland S. Phillips

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C.

County.....

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 706 - A. Street, S. E.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

- - -

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 19, 1948 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 14, 1948 to July 19, 1948

and that I last saw her alive on July 19, 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

open
1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

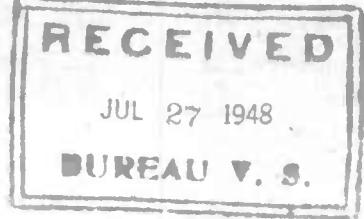
Injured at work?

23. SIGNATURE

Daniel Leo Finegan, M.D.

M. D. or other

Address..... Glenn Dale, Md., Date signed..... 7/19/48.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly
is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160C

07523

232

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

Prune Georges'
rosa Sprout

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Baby Spencer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

July 17, 1948

8. AGE:

Years

Months

Days

If less than one day

hrs. 15 min.

9. Birthplace

Reservoirville Md.
(town, county, and state)

10. Usual occupation

house

11. Industry or business

MOTHER FATHER

12. Name

Ray Josephine Spencer

13. Birthplace

Baltimore Md.

14. Maiden name

Ruth Ellen Marshall

15. Birthplace

Maryland

16. Informant

Ray J. Spencer

Address

Upper Marlboro Md.

17.

(Burial, cremation, or removal, which)

Date thereof July 17, 1948
(month) (day) (year)

Cemetery or crematory

Upper Marlboro

Location

Upper Marlboro Md.

18. Funeral director

Ray J. Spencer

Address

Upper Marlboro Md.

19.

(Date rec'd by registrar)

July 17, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 17, 1948 at 130/11

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. .19. to 19.

and that I last saw h. alive on

Immediate cause of death

Intra cranial birth
injuries

Due to

Premature delivery

DURATION

Due to

Other conditions

Baby about 36 cm long
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town) (County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

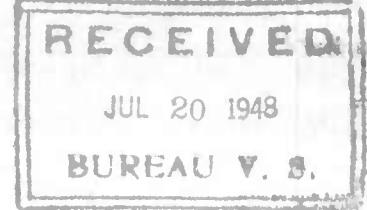
Injured at work?

Deputy medical Examiner

23. SIGNATURE

Date signed 7.17.48
M. D. or other
Forestville Md. Date signed 7.17.48

Address



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07524

CERTIFICATE OF DEATH

Reg. Dist. No. 243

136

1. PLACE OF DEATH: Prince Georges
 County.....
 City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1 mo., 20 days
 Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium
 How long in hospital or institution?..... 1 mo., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D. C. County.....
 City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
 Street No. 3124 M. St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

SPITLER, Guy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife..... Gertrude O'Neill

7. Birth date of deceased (mo., day, yr.) September 26, 1885

8. AGE: Years	Months	Days	If less than one day
62	62	9	7
			hrs. min.

9. Birthplace..... Carroll, Indiana
(Town, county, and state)
 Gardening

10. Usual occupation.....

11. Industry or business.....

FATHER	12. Name..... David Spitler
MOTHER	13. Birthplace..... Carroll, Indiana

14. Maiden name..... Margaret Awlbaugh
15. Birthplace..... Carroll, Indiana

16. Informant..... Deceased

Address.....

17. Removal to Wash. D.C. - July 5, 1948
(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory.....

Location..... Martin N. Hysong

18. Funeral director..... Rowland S. Phillips

Address..... 1300 N. St., N.W.

19. Date rec'd by registrar..... July 5, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 3, 1948, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12, 1948, to July 3, 1948,
 and that I last saw him alive on July 3, 1948.

Immediate cause of death..... Pulmonary Tuberculosis

DURATION..... 14 months

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

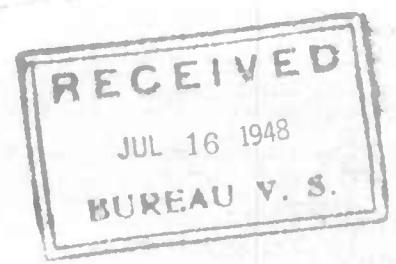
Means of Injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Finegan, M.D.

M. D. or other.....

Address..... Glen Dale, Md.

Date signed..... 7/3/48



Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07525

245

FILE NO. G 116 AUG 4 - 1948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

4909 Tuckerman Street

How long in hospital or institution?

3. (a) FULL NAME

William Stack

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age.....years

7. Birth date of
deceased (mo., day, yr.)

December 31, 1872

8. AGE:

Years 75

Months 6

Days 25

If less than one day

hrs. min.

9. Birthplace Ireland

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

12. Name William Thomas Stack

13. Birthplace Ireland

14. Maiden name Unknown

15. Birthplace Ireland

16. Informant Mrs. Clifton R. King

Address 5800 - 45th Ave., Hyattsville, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 28, 1948

(month) (day) (year)

Cemetery or crematory Cedar Hill

Location S. Anthill, Md.

18. Funeral director Z. Dorsch's Sons

Address Hyattsville, Maryland

July 27, 1948

(Date read by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4909 Tuckerman Street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

577-03-8969

MEDICAL CERTIFICATION

July 25

48

3.30P

2d. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 10. 19.

and that I last saw h. alive on

19.

Immediate cause of death

Coronary Occlusion

DURATION

Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

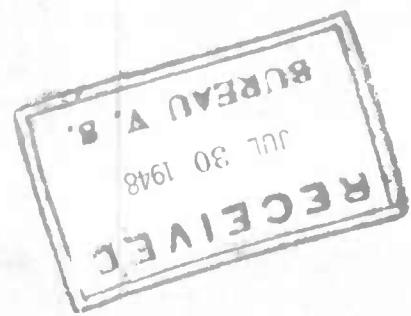
Injured at home, farm, industry, public place (where?)

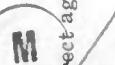
Means of injury Injured at work?

23. SIGNATURE

John J. Maloney, M.D. or other

Address Cheltenham, Md. Date signed 7-29-48





MARGIN RESERVED FOR BINDING

三

10

PLAINLY, WITH EXADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

Reg. Dist. No

07526
No. 243

CERTIFICATE OF DEATH

1. PLACE OF DEATH County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death?..... Hospital, institution, or street address where death occurred:.....			
How long in hospital or institution?.....			
3. (a) FULL NAME George B. Mc Cellan Stewart		3. (b) Social Security Number	
4. Sex Male	5. Color or race white	6. (a) Single, married, widowed, or divorced Married	MEDICAL CERTIFICATION July 10. 48 S. N.P.
6. (b) Name of husband or wife Elizabeth Stewart	6. (c) If alive, give age 60 years		
7. Birth date of deceased (mo., day, yr.) Aug 23. 1863	2D. DATE OF DEATH..... from 15 1948 to July 10 1948		
8. AGE: Years 84	Months	Days	It less than one day hrs. min.
9. Birthplace Ripley W. Va (Town, county, and state)			
10. Usual occupation..... Farmer			
11. Industry or business..... John Stewart			
MOTHER FATHER	12. Name..... John Stewart	13. Birthplace..... unknown	
	14. Maiden name..... Elizabeth Moon	15. Birthplace..... unknown	
16. Informant..... Elizabeth Stewart			
Address Ripley W. Va		Date thereof July 11. 1948	(Burial, cremation, or removal, Which?)
(Burial, cremation, or removal, Which?)			
17. Cemetery or crematory..... Ripley W. Va			
Location..... L. Gauching song			
18. Funeral director..... Ripleytonille Md.			
Address.....			
19. Date rec'd by registrar July 10 48 Amanda Downey	Registrar..... Robert Mc Henry Jr.	M. D. or other Samuel Md	Date signed 7/10/48
20. I CERTIFY that death occurred on the date above stated; that I attended deceased from from 15 1948 to July 10 1948 and that I last saw him alive on July 11 1948			
Immediate cause of death..... Chronic myocarditis.			
DURATION 3 years			
Due to.....			
Due to.....			
Other conditions..... (Include pregnancy within 3 months of death)			
Major findings of operations..... Date of op.....			
Autopsy results.....			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following:			
Accident, suicide, or homicide..... Date of.....			
Where did injury occur?..... (City or town)..... (County)..... (State).....			
Injured at home, farm, industry, public place (where?).....			
Means of injury..... Injured at work?			
23. SIGNATURE..... Robert Mc Henry Jr.			
Address..... Samuel Md			

RECEIVED

JUL 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07527 275

1. PLACE OF DEATH: Poage County Hospital
 County: Poage
 City or town: Poage
 (If outside city or town limits, write RURAL and give nearest town) 3 hr. Hospital
 How long in above place of death? 3 hr.
 Hospital, institution, or street address where death occurred: 3 hr.
 How long in hospital or institution? 3 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Md. County: Poage
 City or town: Bethelville
 (If outside city or town limits, write RURAL and give nearest town) 870
 Street No.: 870
 (If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number: _____

3. (a) FULL NAME

SALLY LAULMAN STUART

4. Sex: Female 5. Color or race: White 6.(a) Single, married, widowed, or divorced: Married
 6.(b) Name of husband or wife: W.H. Laulman
 7. Birth date of deceased (mo., day, yr.): Oct 30 1877 8. (c) If alive, give age: 70 years
 8. AGE: Years: 70 Months: Oct Days: 30 If less than one day: hrs. min.
 9. Birthplace: MT. HOLY SPRING, PENNA (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

MOTHER FATHER	12. Name: <u>W. H. LAULMAN</u>
	13. Birthplace: <u>Dillsberg, Penna</u>
MOTHER	14. Maiden name: <u>SALLY ANN Zug</u>
	15. Birthplace: <u>MT. HOLY SPRING, PENNA</u>

16. Informant: SALLY S. BushAddress: Bethelville, Md17. Burial, cremation, or removal. When? Bur. R.I.A.L. Date thereof: July 27 1948
 (Burial, cremation, or removal. When?) (month) (day) (year)Cemetery or crematory: McCormick CemeteryLocation: MT. HOLY SPRINGS, GARLIE, PENNA18. Funeral director: W. R. SelbyAddress: LAUREL, MARYLAND19. (Date rec'd by registrar) July 27 1948 James Berry, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 - 1948 at 9p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-2-4 to July 23 1948 and that I last saw her alive on 7-2-3 1948.Immediate cause of death: Cerebral Hemorrhage DURATION: 3 hr.Due to: strychnine - myocarde DURATION: 3

Due to: _____

Other conditions: _____

(Include pregnancy within 8 months of death)

Major findings of operations: _____ Date of op.: _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: 7/23/48 M. D. or other: _____Address: Lance Rd Date signed: 7/24/48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07528 234
Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Prince George's

Clinton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 hours

Hospital, institution, or street address where death occurred:

Prestonway Road

How long in hospital or institution?

3. (a) FULL NAME

maggie Virginia Tappan

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white Widowed

6.(b) Name of husband or wife

George A. S. Tappan

7. Birth date of deceased (mo., day, yr.)

1878

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Maryland

10. Usual occupation

Housewife

11. Industry or business

Bun House

FATHER

12. Name

Henry Valley

13. Birthplace

Maryland

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Charles Andrew Tappan

Address

Clinton, MD

17. Burial

Date thereof

7-27-48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

57 Mary

Location

Prestonway Rd

18. Funeral director

Smith & Rogers

Address

Walney 2nd

19. Date rec'd by registrar

19-48

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Prince George's

City or town Clinton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 23 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., fo....., 19.....

and that I last saw h.....alive on.....

Immediate cause of death

Acute congestive heart

failure

Due to.....Endopercarditis cerebral

disease

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....(City or town).....(County).....(State).....

Injured at home, farm, industry, public place (where?)

Means of injury

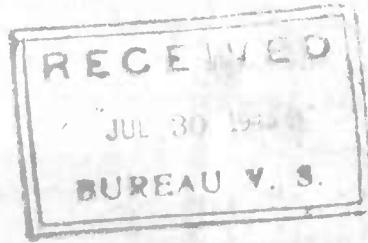
Injured at work?

Deputy medical examiner

23. SIGNATURE

M. D. or other

Address Westville Inn Date signed July 23 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

07529

230

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Prince Georges'

County LAKELAND

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution street address where death occurred:

4808 Lakeland Road

How long in hospital or institution?

3. (a) FULL NAME

BEATRICE (NMN) THOMAS

4. Sex

FEMALE Colored

5. Color or race

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

William Joseph

7. Birth date of deceased (mo. day. yr.)

MAY 15 - 1896

6.(c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

52 1 20

hrs.

min.

9. Birthplace

WASHINGTON, DC.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

SAMUEL Hughes

MOTHER FATHER

12. Name

MARYLAND

13. Birthplace

HARRIET Hughes

14. Maiden name

MARYLAND

15. Birthplace

WILLIAM Joseph Thomas

16. Informant

LAKELAND, Md.

Address

17. Burial

Date thereof July 8 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory Lincoln Cemetery

Location

Prince George

18. Funeral director

Henry S Washington & Sons

Address

467 N St. N.W. Wash. D.C.

19. July 8th 1948
(Date rec'd by registrar)John D Smith
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges'

City or town Lakeland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4808 Lakeland Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

5 July 48 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

5 June 48 to 5 July 48

and that I last saw him alive on 9 July 1948

Immediate cause of death

METASTATIC CARCINOMA
OF LUNGS, BILATERAL

DURATION

9 mos

Due to

CARCINOMA OF
TREAS

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

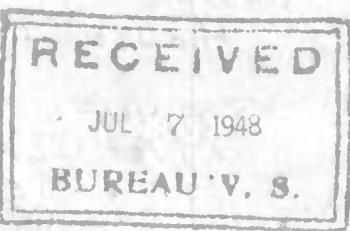
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Elle E. Eleune
Berwyn, Md. M. D. 7-5-48
Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61
07530

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town Hyattsville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred: 4922-40th Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4922-40th Place
(If rural, give LOCATION)

3. (a) FULL NAME
Maggie May Tierney
4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife John Tierney
7. Birth date of deceased (mo., day, yr.) June 30, 1884 6. (c) If alive, give age 78 years
8. AGE: Years Months Days If less than one day 64 6
9. Birthplace Cambridge, Maryland
(Town, county, and state)
10. Usual occupation Waitress
11. Industry or business Construction
12. Name William Burton
13. Birthplace Maryland
14. Maiden name Hester Ann Thomas
15. Birthplace Maryland
16. Informant Elsie May Travers
Address 4922-40th Place, Hyattsville, Md
17. Burial Date thereof July 9, 1948
(Burial, cremation, or removal. Which?) Month (day) (year)
Cemetery or crematory Cambridge Cemetery
Location Cambridge Md
18. Funeral director F. Busche son
Address Hyattsville Md
19. Date rec'd by registrar July 9, 1948 Mrs. Jas. Dierer
(Date rec'd by registrar) Deputy, Local Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 19 48 at 9.15A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. . . . to 19. . . .

and that I last saw h. . . . alive on 19. . . .

Immediate cause of death

Hypertensive Heart Disease

Due to

Due to

Other conditions Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

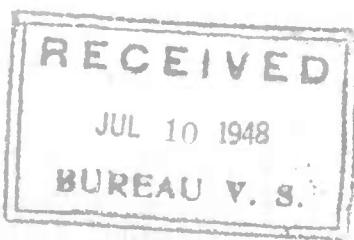
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John J. Maloney, Dep. Health Exam
M. D. or other
Address Cheverly, Hyattsville Date signed 7-6-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

112

0753231

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... Prince George

City or town... Cheverly Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 da 8 hr 10 min

Hospital, institution, or street address where death occurred:

Prince Georges Gen'l Hosp. 1st

How long in hospital or institution? 1 da 8 hr 10 min

3. (a) FULL NAME

Martha G Gilson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

f white married

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day. yr.)

June 15, 1870

8. AGE:

Years

Months

Days

If less than one day

28

19

hrs.

min.

9. Birthplace.....

New York
(Town, county, and state)

10. Usual occupation.....

at home

11. Industry or business

Wm Goodrich

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

19. (Date rec'd by registrar).....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md

County... Pro Geo

City or town... City of Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

Street No... 6007-41 Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 7-4 1948 at 5 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-1 1948 to 7-4 1948

and that I last saw her alive on 7-3 1948

Immediate cause of death..... Pulmonary edema

Atrophy & Emphysema

DURATION

2 yrs

Due to..... Chronic Bronchitis
Asthma

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results..... Some

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE..... Wm. Marquess M.D.

M. D. or other

Address..... Mt. Rainier Md. Date signed..... 7-4-48

RECEIVED
JUL 7 1948
BUREAU Y. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

192

07532

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH:

Prince Georges

County

Cheverly

City or town.

(If outside city or town limits, write RURAL and give nearest town)

2 hours

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Raymond Stanley Weaver

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

single

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 21, 1933

8. AGE: Years Months Days It less than one day

15

5

23

..... hrs. min.

9. Birthplace San Diego California

(Town, county, and state)

student

10. Usual occupation

11. Industry or business

12. Name Austin Wallace Weaver

13. Birthplace Craigsville Virginia

14. Maiden name Cecilia Caplis

15. Birthplace Boston Mass

16. Informant Mrs Cecilia Weaver

Address Cheverly Md.

17. Burial

Date thereof July 17, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Colmar Manor Md.

18. Funeral director F. Gasch's Sons

Address Hyattsville Md.

19. 7/16 1948

(Date rec'd by registrar)

19. 1948

Amanda Downey

Registrat

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Prince George's

City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2409 Cheverly avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 14 1948 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18... to... 19...

and that I last saw h..... alive on

19...

Immediate cause of death

asphyxia

19...

Due to

Electric shock

Died to

Lightning

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Crucifix July 14, 1948

Where did injury occur?

Cheverly B. G. M. D.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

farm

Means of injury Stun by lightning

Injured at work?

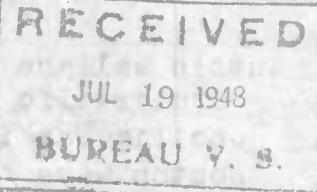
23. SIGNATURE John J. Maloney, Dep. M.D.

Garrison

Address Cheverly-Hyattsville

7-15-48

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

126

0753343

Reg. Diet. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

39 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Samuel Manley Whedbee

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Married

6. (b) Name of husband or wife

Annie C. Whedbee

7. Birth date of deceased (mo., day, yr.)

Nov 17, 1878

B. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Ga

(Town, county, and state)

10. Usual occupation

Telegraph

operator

11. Industry or business

MOTHER

FATHER

12. Name

George W. Whedbee

N.C.

13. Birthplace

Mary Blunt

N.C.

14. Maiden name

Annie C. Whedbee

15. Birthplace

Annie C. Whedbee

16. Informant

Address

seabrook

Md.

Burial

Date thereof

July 20, 1948

(Burial, cremation, or removal. Which?)

Glendale Cemetery

Cemetery or crematory

Glendale

Md.

Location

F. Knoblauch sons

Hyattsville

Md.

Funeral director

Address

Hyattsville

Md.

July 20, 1948

Amanda Dorsey

Registrar

John D. Bayly

M. D. or other

Eye M.W.

Address

1726

Date signed

3/15/48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

Copy

Prince George

City or town

Seabrook

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 18, 1948 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 25, 1948 to July 16, 1948

and that I last saw him alive on July 16, 1948.

Immediate cause of death

Cholera

DURATION

week

Due to Cirrhosis of Liver

Due to

Other conditions

Cholelithiasis

(Include pregnancy within 3 months of death)

Major findings of operations

Cholelithiasis, Ascites

Cirrhosis of Liver

Date of op.

6/8/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

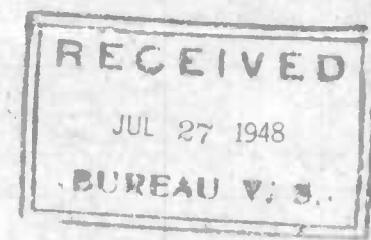
John D. Bayly

M. D. or other

Eye M.W.

Address

1726 Date signed 3/15/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1753242

93d

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 yrs.

Hospital, institution, or street address where death occurred:

7703 Emerson Rd. West Lanham Hills Md.

How long in hospital or institution?.....

3. (a) FULL NAME

ANNIE Z. WHITE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALE White widowed.

8. (b) Name of husband or wife.....

RALPH White

7. Birth date of deceased (mo. day, yr.)

B. (c) If alive, give age..... years

About 1863

8. AGE: Years Months Days If less than one day

55 hrs. min.

9. Birthplace..... ONTARIO Canada

(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name..... FELIX PINSINAUT

13. Birthplace..... CANADA

14. Maiden name..... ZINNAD PILON

15. Birthplace..... CANADA

16. Informant..... Mrs. Catherine Tyler daughter

Address 7703 Emerson Rd. Whelan Hll, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory..... Fort Lincoln Cemetery

Location Colmar Manor, Md.

18. Funeral director..... W.W. Chambers Co.

Address 517 11th St SE

19. (Date rec'd by registrar) 7/28 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Prince George

City or town..... West Lanham Hills Md.

Street No. 7703 Emerson Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 7/28/1948 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 26, 1948, to July 28, 1948
and that I last saw h. J. alive on July 28, 1948, 19.

Immediate cause of death.....

Congestive Heart Failure

DURATION

Due to..... Arterio-Sclerosis

Due to.....

Other conditions..... Herniated Edem.

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... 1287 1/2

Date signed..... 7/28/48

RECEIVED
AUG 2 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07535
232
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 weeks

Hospital, institution, or street address where death occurred:

60. Jail

How long in hospital or institution?.....

3. (a) FULL NAME

William Wilby (Wilkes)

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male Colored

Married

6.(b) Name of husband or wife.....

Carrie Brown Wilkes

6.(c) If alive, give age..... years

7. Birth date of deceased (mo..day..yr.)

Jan. 29, 1874

8. AGE:

Years

Months

Days

If less than one day

75

5

13

hrs.

min.

9. Birthplace.....

Poplar Hill, Md.

(Town, county, and state)

10. Usual occupation.....

Farmer.

11. Industry or business

MOTHER FATHER

12. Name..... Robert Wilkes

13. Birthplace..... Poplar Hill

14. Maiden name..... Chrissie Brown

15. Birthplace..... Poplar Hill

16. Informant..... John Louis Brown

Address..... Upper Marlboro R.R. 1. Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... July 15, 1948

(Month) (day) (year)

Cemetery or crematory..... Holy Rosary Cemetery

Location..... Rosaryville, Md.

18. Funeral director..... Ritchie Bros.

Address..... Upper Marlboro, Md.

19. Date rec'd by registrar..... July 13, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war..... No

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

July 12, 1948 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 24, 1948, to July 11, 1948,

and that I last saw him alive on July 11, 1948.

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

24 hrs

Due to.....

Due to.....

Other conditions.....

Contusions

20 min

(Include pregnancy within 3 months of death)

Major findings or operations.....

None

Date of op.....

Autopsy results.....

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

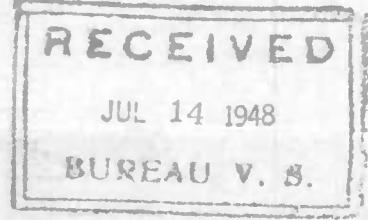
Injured at work?

23. SIGNATURE..... James F. Sasser

M. D. or other

Address..... Upper Marlboro, Md.

Date signed..... July 12, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136

07536

243

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos., 9 days

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 6 mos., 9 days

3. (a) FULL NAME

WIMBUSH, GEORGIANA

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

May 2, 1932

8. AGE: Years

16

Months

16

Days

2

If less than one day

21 hrs. min.

9. Birthplace.....

Washington, D. C.

(Town, county, and state)

10. Usual occupation.....

Student

11. Industry or business

12. Name..... Clifton Wimbush

13. Birthplace..... ? Virginia

14. Maiden name..... Julia Thompson

15. Birthplace..... ? Virginia

16. Informant.....

Address

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... July 27, 1948

(month) (day) (year)

Cemetery or crematory.....

woodlawn Cemetery

Washington, D.C.

Location.....

R. M. Barton Co

18. Funeral director.....

Address..... 1323 30th St. N.W. Wash. D.C.

19. Date rec'd by registrar..... July 23, 1948 Rowland S. Phillips

(Date rec'd by registrar) (Signature) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C.

County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 346 - H. Street, S. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 23, 1948 at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/3 1948 to 7/23 1948

and that I last saw him alive on 7/23

1948

Immediate cause of death.....

pulmonary tuberculosis

DURATION

7 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

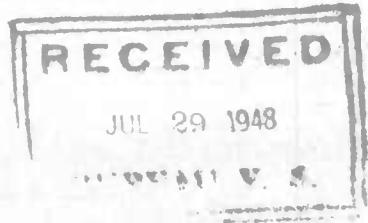
Injured at work?

23. SIGNATURE

Daniel L. Finucane M.D. M. D. or other

Glen Dale, Md. Date signed 7/23/48

Address



13/a

CERTIFICATE OF DEATH

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The physician's name is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County.....*Prince George*
City or town.....*Clinton* (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *3 years*
Hospital, Institution, or street address where death occurred:
Shrub road
How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Prince George's
 City or town Clinton (If outside city or town limits, write RURAL and give nearest town)
 Street No. Theft road (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME William Ernest Windsor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
<u>Male</u>	<u>White</u>	<u>Widower</u>		
6.(b) Name of husband or wife.		<u>Catherine Diane Wurd</u>		
		6.(c) If alive, give age..... years		
7. Birth date of deceased (mo., day, yr.)		<u>May 30, 1878</u>		
8. AGE:	Years <u>70</u>	Months /	Days /	If less than one day hrs. min.
9. Birthplace.....	<u>Maryland</u> (Town, county, and state)			

MEDICAL CERTIFICATION		
2D. DATE OF DEATH.	July 13	1948, at 6 ⁰⁰ /10
✓ 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from		
	19....., to.....	19.....
and that I last saw h..... alive on		19.....
Immediate cause of death.....	DURATION	
<i>Acute Congestive Heart failure</i>		
Due to.....		
<i>Cardiovascular renal disease</i>		
Other conditions		

MOTHER FATHER	12. Name.....	William Pink Wessendorf
	13. Birthplace	Maryland
	14. Malden name.....	Eleanor Jenkins
	15. Birthplace	Maryland
	16. Informant.....	Theresa T. Wessendorf
	Address	Clinton, Md
17.	Burial..... (Burial, cremation, or removal. Which?)	Date thereof..... 7-15-48 (month) (day) (year)
	Cemetery or crematory.....	St Johns
	Location.....	Clinton and
18.	Funeral director.....	Hannett & Kyger
	Address	Wadley and
19.	7/14.....1948..... (Date rec'd by registrar)	Issued by F. B. I. - Monroe City, Co. Registrars

(Include pregnancy within 3 months of death)	
Major findings of operations.....	Date of op.
Autopsy results.....	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide.....	Data of
Where did injury occur?	(City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)	
Means of injury	Injured at work?
<u>Weapon medical Examiner</u> 23. SIGNATURE..... <i>[Signature]</i> D.O.B. _____ Address..... <i>Foxestall Rd</i> Date signed	

